Decolonizing Madness

01_Fanon_prelims.indd i 10/7/2014 5:41:19 PM

01_Fannon_prelims.indd ii 10/7/2014 5:41:20 PM

Decolonizing Madness

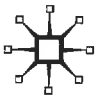
The Psychiatric Writings of Frantz Fanon

Edited by

Nigel Gibson

palgrave
macmillan

01_Fannon_prelims.indd iii 10/7/2014 5:41:20 PM



DECOLONIZING MADNESS
Copyright © Nigel Gibson, 2014.

All rights reserved.

First published in 2014 by
PALGRAVE MACMILLAN®
in the United States—a division of St. Martin's Press LLC,
175 Fifth Avenue, New York, NY 10010.

Where this book is distributed in the UK, Europe and the rest of the world, this is by Palgrave Macmillan, a division of Macmillan Publishers Limited, registered in England, company number 785998, of Houndmills, Basingstoke, Hampshire RG21 6XS.

Palgrave Macmillan is the global academic imprint of the above companies and has companies and representatives throughout the world.

Palgrave® and Macmillan® are registered trademarks in the United States, the United Kingdom, Europe and other countries.

ISBN: 978–1–137–34227–0

Library of Congress Cataloging-in-Publication Data is available from the Library of Congress.

A catalogue record of the book is available from the British Library.

Design by Newgen Knowledge Works (P) Ltd., Chennai, India.

First edition: XXXX 2014

10 9 8 7 6 5 4 3 2 1

Contents

List of Figures vii

Preface ix
Alice Cherki

Translator's Preface xiii
Lisa Damon

Acknowledgments xvii

Introduction 1
Nigel C. Gibson

1 The "North African Syndrome" 41
2 Mental Disorders and Neurological Disorders 51
3 Aspects of Psychiatric Care in Algeria Today 65
4 Sociotherapy on a Ward for Muslim Men: Methodological Difficulties 73
5 The Conduct of Confession in North Africa 87
6 Ethnopsychiatric Considerations 91
7 The TAT and Muslim Women: A Sociology of Perception and Imagination 93
8 An Introduction to Sexual Disorders Amongst North Africans 97
9 The Maghrebi Muslim Attitude toward Madness 103
10 The Phenomenon of Agitation in Psychiatry: General Considerations and Psychopathological Significance 107
11 Letter to the Resident Minister 113
Appendix: Police Intelligence Service Personal File on Dr. Fanon 117
12 Day Hospitalization in Psychiatry: Its Value and Limitations 119
13 The Encounter of Society and Psychiatry 145

Afterword: Frantz Fanon. From a Phenomenology of Oppression to the Birth of a Critical Ethnopsychiatry, Roberto Beneduce 155

Appendix of Proper Names 185

Index 189

01_Fannon_prelims.indd vi 10/7/2014 5:41:22 PM

Figures

12.1	Duration of patient stay at the CNPJ	123
12.2	Patient age pyramid (1958)	124
12.3	Family context: comparing men and women	125
12.4	Economic condition of male patients (diagnostics)	125
12.5	Economic condition of female patients by profession of the parent or her husband	127
12.6	Geographic situation of patients	128
12.7	1958 Diagnostics	129
12.8	Duration of patient stay at the CNPJ (1959)	130
12.9	Patient age pyramid (1959)	130
12.10	Family context: Comparing men and women (1959)	131
12.11	Economic condition of male patients	131
12.12	Economic condition of female patients	132
12.13	1959 Diagnostics	132

01_Fannon_prelims.indd vii 10/7/2014 5:41:22 PM

Chapter 1

The "North African Syndrome"*

We often say that man is ever a question to himself, and that it would be a denial of self to claim otherwise. However, it seems that it should be possible to delineate a basic dimension common to all human problems. Or more precisely, that all the problems man faces on the subject of man can be reduced to this one question:

> "Have I not, because of what I have done or failed to do, contributed to an impoverishment of human reality?"

Or formulated differently:

> "Have I, in all circumstances, called forth the human inside me?
>
> I want to show in these pages that a theory of inhumanity threatens to find its laws and its corollaries in the case of the North African emigrated to France.
>
> All those men who are hungry, all those men who are cold, all those men with fear...
>
> All those men we fear, who crush the jealous emerald of our dreams, who twist the fragile curve of our smiles; all those men before us, who ask us no questions, but to whom we put strange ones.
>
> Who are they?
>
> I ask you. I ask myself. Who are they, those creatures starving for humanity who stand braced against the impalpable borders of full recognition (though I know them from experience to be terribly distinct)?
>
> Who are they really, those creatures who hide, who are hidden by social truths behind the names *bicot, bounioule, arabe, raton, sidi, mon z'ami*?[1]

Thesis I.—*That the behavior of the North African often provokes suspicion in the medical staff as to the reality of his illness.*

Other than emergency cases—intestinal occlusions, wounds, and accidents—the North African presents himself cloaked in vagueness.

His stomach hurts, his head and back hurt, it hurts everywhere. He suffers terribly, his face is eloquent, his suffering undeniable:

03_Fanon_cha01.indd 41 10/7/2014 5:37:23 PM

- What is it my friend?
- I am dying, *monsieur le docteur.*

His voice is broken, almost imperceptible.

- Where does it hurt?
- Everywhere, *monsieur le docteur.*

You must not ask for precision: you won't get any. For example, it is important to have a sense of time between pains in the case of ulcerous afflictions. Yet the North African seems hostile to conforming to categories of time. Not from lack of understanding as he often comes accompanied by an interpreter. It seems arduous for him to go back to where he no longer is. The past, for him, is a distressing one. What he hopes for is to never suffer again, to never come face to face with that past again. The present pain, which visibly mobilizes the muscles of his face, is quite enough. He does not understand why we would have him recall, even to memory, the pain that is already gone. He does not understand why the doctor asks him so many questions:

- Where does it hurt?
- In my belly. (He points to his thorax and abdomen.)
- When?
- All the time.
- Even at night?
- Especially at night.
- So, it hurts more at night than during the day?
- No. All the time.
- But more at night than during the day?
- No. All the time.
- And where does it hurt the most?
- Here. (He points to his thorax and abdomen.)

And so it is. Other patients are waiting outside and the worst is that it does not seem like more time would change anything. We therefore start with a probable diagnosis and correspondingly propose an approximate therapy.

- Follow this treatment for a month. If you don't get better, come back to see me.

Two things might happen:

1. The patient is not immediately relieved and he comes back three or four days later. This sets us against him since we know there is a lag before the prescribed medication has an effect on the lesion.

   We make him understand, or more exactly, we tell him so. But our patient doesn't hear it. He *is* his pain and refuses to understand any kind of language and it is but a short step to the conclusion:

03_Fannon_cha01.indd 42 10/7/2014 5:37:23 PM

It is because I am Arab that they are not treating me like everyone else.

2. The patient is not immediately relieved but does not return to the same dispensary or the same doctor.

He goes elsewhere. He goes on the assumption that in order to get satisfaction he must knock at every door. And he knocks. He knocks relentlessly. Gently. Naively. Furiously.

He knocks. The door is opened. It always is. And he tells *his pain* as it becomes more and more his own. He expounds on it with volubility now. He grasps it and places it under the doctor's nose. He takes it and touches it with his ten fingers, develops it, exposes it. It grows before our eyes. He gathers it over the whole surface of his body and after 15 minutes of gestured explanations, the interpreter (understandably disconcerted) translates for us: he says his stomach hurts.

All of those spatial incursions and wide-eyed facial spasms were only meant to express a vague sense of pain. We feel frustrated with the explanation. The comedy, or drama, begins all over again with an approximate diagnosis and therapy.

There is no reason for the wheel to stop going round. Some day an X-ray will show an ulcer or gastritis. Or more likely, nothing at all. His ailment will be described as "functional."

This is an important notion to consider. A thing is said to be vague when it lacks in consistency, in objective reality. The North African's pain, for which we can find no lesional basis, is found to have no consistency, no reality. However the North African *is* also the-kind-who-doesn't-like-work, such that everything he does is interpreted *a priori* on this basis.

A North African is hospitalized because he suffers from lassitude, asthenia, and weakness. He is given active treatment based on restoratives. After 20 days we decide to discharge him. He then discovers he has another illness:

- My heart is fluttering in there.
- My head is bursting.

Faced with this fear of leaving, we begin to wonder whether the weakness for which he was treated was not due to some kind of frivolity. We begin to wonder if this patient we never quite understood hasn't played us. Suspicion rears its head. From now on, we will be wary of alleged symptoms.

The matter is perfectly clear in the winter; and so certain wards are literally submerged by North Africans during severe cold spells. It is so nice and warm in a hospital room.

In one ward, a doctor was scolding a European with sciatica for wandering about the corridors all day long. He explained that rest was half of the treatment for his particular ailment. With the North Africans, he added for our benefit, the problem was different: no need to prescribe rest; they're always in bed.

Faced with this pain without lesion, this illness spread over and throughout the whole body, this constant suffering, the easiest attitude, to which one is led more or less quickly, is to deny any existence of morbidity. The extreme version of which is "the North African is a faker, a liar, a shirker, an idler, a phony, a thief."[2]

Thesis II.—*That the medical personnel very often take on an a priori attitude. The North African does not arrive on grounds common to his race but on a foundation built by the European. In other words, the North African enters spontaneously, by his very presence, into a preexisting framework.*

For the past several years, a new trend has appeared in medicine that we might expediently call neo-Hippocratism. It has doctors focus more on making a diagnosis of function and less on diagnosing organs when faced with a patient. But this kind of thinking has not yet left its mark in the departments where pathology is taught. There is a foundational flaw in the practitioner's thinking. A very dangerous one.

We shall see how it manifests itself in practice.

I am called in for an emergency consultation. It is two o'clock in the morning. The room is dirty; the patient is dirty. His parents are dirty. Everyone is weeping. Everyone is shouting. There is an eerie sense that death is nigh. The young doctor casts away any sense of disconcertion. He leans "objectively" over the patient's stomach, which shows all signs of needing surgery.

He touches and palpates and taps and questions but is met only with groans. He palpates again, taps once more, and the stomach contracts, resists... He "sees nothing." But what if it does require surgery? What if he is missing something? His examination is negative but he dares not leave. After much hesitation, he transfers his patient to another center with the recommendation to operate. Three days later, the "stomach operation" in question enters his office smiling, completely cured. And what the patient is unaware of is the existence of a rigorous medical thought process that he has just gone and flouted.

Medical thinking proceeds from symptom to lesion. Agreement has been reached in the illustrious assemblies, in the international medical congresses on the importance of the neurovegetative systems, the diencephalon, the endocrine glands, the psychosomatic links, the sympathalgias, but doctors continue to be taught that every symptom requires its lesion. Any patient who complains of headaches, ringing in the ears, and dizziness must also have high blood pressure. But if these same symptoms are present with no sign of high blood pressure or brain tumors or anything testing positive, the doctor will have to conclude that medical thinking is at fault; and since any thinking is thinking about something, he will find the *patient* at fault—an indocile, undisciplined patient unaware of the rules of the game. The rule, ever so strict, that states: every symptom presupposes a lesion.

What am I to do with this patient? He returns from the unit I sent him to for probable surgery diagnosed with a case of "North African syndrome." And it is true that any young doc newly arrived will surely find echoes of Molière in the North Africans he treats. Imaginary invalid! If Molière (what I am about to say is inane but this whole description only highlights and makes all the more flagrant a much vaster inanity); if Molière had had the privilege of living in the twentieth century, he would certainly not have written *Le Malade imaginaire*, since there is no doubt in anyone's mind that Argan is ill. Ill, he is actively so:

Comment, coquine! Si je suis malade! Si je suis malade, impudente!

[What, you minx! If I'm really sick! If I'm really sick, what impudence!]

The North African syndrome. Nowadays, the North African who comes to consult comes bearing the dead weight of all his compatriots. All of those who only had

03_Fannon_cha01.indd 44 10/7/2014 5:37:24 PM

symptoms; all of those of whom it was said: "Nothing there to sink your teeth into" (Meaning: no lesion.) Yet the patient that stands before me, this body I must assume to be permeated by a consciousness, this body that is no longer quite body, or rather doubly so since it is beside itself with terror—this body that calls on me to listen to it without, however, dwelling on it—appalls me:

- Where does it hurt?
- My stomach. (He points to his liver.)

I get angry. I tell him the stomach is on the left, that where he's pointing is the location of the liver. He doesn't falter. He runs the palm of his hand over that mysterious belly:

- All of this hurts.

I happen to know that there are three possible organs in "all of this"—five or six to be exact. That each of these organs has its *own* pathology. The pathology invented by the Arab does not interest us. It is a pseudo-pathology. The Arab is a pseudo-invalid.

All Arabs are imaginary invalids. The young doctor or medical student who has never seen a sick Arab *knows* (thanks to the old medical tradition) "these guys are jokers." There is one thing worth noting: the student or doctor will tend to use the second person singular when addressing an Arab. It's to be nice, we're told... to make them feel comfortable... they're used to it... My apologies, but I find myself unable to analyze this phenomenon without abandoning the objective approach I have tried to maintain.

"I can't help it," an intern once told me, "I just can't talk to them like I do other patients."

Yes, of course! I can't help it. If you only knew the things in my life that I can't help. If you only knew the things in my life that beleaguer me in the hours when others numb their minds. If you only knew... but you don't.

The medical personnel discovers the existence of a North African syndrome. Not experimentally but by oral tradition. The North African is fit into this asymptomatic syndrome and automatically situated as undisciplined (*cf.* medical discipline), inconsequential (in regard to the law that says to every symptom, its lesion), insincere (he claims to be suffering while we know there is no *reason* for his suffering). There is an idea here, floating around at the limits of my good faith, and when the Arab reveals himself through his language:

> "Monsieur le docteur, I am dying."
>
> This idea, having undergone many convolutions, will impose itself; it will impose itself on me.
>
> No, these guys really can't be taken seriously.

Thesis III.—*That the best intentions, the purest intentions need to be questioned—On the necessity of making a situational diagnosis.*

Dr. Stern, in an article on psychosomatic medicine that takes up the work of Heinrich Meng, writes: "It is not only a matter of finding out which organ is ailing, what the nature of organic lesions is, if they are present, and what germ has invaded the organism; it is not enough to know the 'somatic constitution' of the patient but rather we must try to find out what Meng calls his 'situation'; in other words, his close relationships, occupations and preoccupations, his sexuality and inner tension, his sense of security or insecurity, the dangers he faces; and we may also add his evolution, the story of his life. One must make a 'situational diagnostic'."[3]

Dr. Stern proposes a magnificent plan that we intend to follow:

1) *Close relationships*—Is this really worth mentioning? Is it not somewhat laughable to talk about the North African's close relationships in France? Does he have relationships? Is anyone close? Is he not alone? Are they not alone? Do they not seem to us absurd, meaning without substance, in the trams or trolleybuses? Where are they coming from? Where are they going? From time to time we see them working on this or that building site, but we don't actually *see* them, we notice them, we glimpse them. Relationships? Close? There is no contact; only clashes. Do we even understand what the term contact suggests of warmth and politeness (not policing, but politeness)? Is there contact? Are there relations?
2) *Occupations and preoccupations*—He works, he is occupied. His preoccupations? I don't think the word exists in his language. Preoccupied with what? In France we say: he is preoccupied with finding work; in North Africa: he is occupied finding work.
   - Excuse me Madame, but in your opinion, what are the preoccupations of a North African?
3) *Sexuality*—Yes, I hear you: it consists of rape. To show how prejudicial a scotomizing study can be to the authentic unveiling of a phenomenon, I would like to reproduce a few sentences here from a doctoral thesis in medicine defended in Lyon in 1951 by Dr. Léon Mugniery:

> "In the region of Saint-Etienne, eight out of ten have married prostitutes. Most of the others have short-term, accidental relationships, sometimes on a marital basis. They will often lodge one or several prostitutes for a few days and invite their friends to visit them."
>
> "*For prostitution seems to play an import role in the North African community*[4]... It is due to the strong sexual appetite characteristic of these hot-blooded southerners."

Further on:

> "Undoubtedly objections can be made and numerous examples cited to show the failure of all attempts made to provide decent housing for the North Africans."
>
> "These are mostly young men (aged 25 to 35) with considerable sexual needs that can only temporarily be met by the bonds of a mixed marriage, and with a disastrous penchant for homosexuality."
>
> "There aren't very many solutions to the problem: either we encourage families to reunite in France and bring over young Arab girls and women, despite the

03_Fannon_cha01.indd 46 10/7/2014 5:37:25 PM

risks[5] occasioned by a kind of invasion of the Arab family; or we must tolerate the presence of brothels for them."

"If we were to ignore these factors, we would risk being exposed to more and more attempts at rape of the kind so often reported in the newspapers. Public morality surely has more to fear from this than from the existence of licensed brothels."

And to conclude, Dr. Mugniery denounces the French government's error by writing in bold capital letters the following sentence: "THE GRANTING OF FRENCH CITIZENSHIP CONFERRING EQUAL RIGHTS SEEMS TO HAVE BEEN PRECIPITOUS AND BASED ON SENTIMENTAL AND POLITICAL REASONS MORE THAN ON THE SOCIAL AND INTELLECTUAL EVOLUTION OF A RACE ENDOWED WITH A SOMETIMES REFINED CIVILIZATION YET STILL PRIMITIVE IN TERMS OF SOCIAL, FAMILY AND SANITARY BEHAVIOR." (p. 45)

Need anything be added? Must we take up each of these absurd phrases, one after the other? Must we remind Dr. Mugniery that if the North Africans in France make do with prostitutes, it is first, because prostitutes are available in France, and second, because Arab women (who might invade the nation) are not.

4) *His inner tension*—Completely nonexistent? Might as well talk about the inner tension of a stone. Inner tension indeed! What a joke!
5) *His sense of security or insecurity*—The first term might as well be dropped. The North African is in a perpetual state of insecurity. A multipronged insecurity.

> I wonder sometimes if it wouldn't be right to reveal to the average Frenchman what a misfortune it is to be North African. The North African is never sure of anything. He has rights, you might say, but he doesn't know them. Aha! It's up to him to know them. Knowledge. Ah yes! Here we are again. Rights, Responsibilities, Citizenship, Equality, what beautiful things! The life of the North African on the threshold of the French Nation—that also belongs to him, we are told—is an imbroglio on the political and civic level that no one wishes to face head on. What does this have to do with the North African in a hospital context? There just so happens to be a connection.

6) *The dangers he faces*—

> His affectivity endangered,
> His social activity endangered,
> His belonging to the polis endangered,
> All the conditions are met in the North African to make a sick man.
>
> Without family, without love, without human relations, without the possibility of communion with the collectivity, his first encounter with himself will occur in a neurotic mode, a pathological mode; he will feel emptied, lifeless, in a bodily struggle with death, a death short of death, a death in life. And what could be more pathetic than such a robust, muscular man who tells us in his truly broken voice: "Doctor, I am dying."

7) *His evolution and the story of his life*—We may as well say the story of his death. A daily death.

A death in the tram,
A death at the doctor's office,
A death with the prostitutes,
A death on the building site,
A death at the cinema,
A multiple death in the newspapers,
A death in the fear of all those decent folk to go out after midnight,
A death,
Yes, a DEATH.

This is all fine and well, you might say, but what solutions do you propose?
You must admit, they are vague, amorphous...
"You constantly have to be on their backs."
"You have to push them out of the hospital."
"If you listened to them, you would prolong their convalescence indefinitely."
"They can't express themselves."
And they are liars
And also, they are thieves (*voleur comme un arabe*[6])
And also, and also, and also
The Arab is a thief
All Arabs are thieves.
It's a good-for-nothing race
Dirty
Disgusting
Nothing to do about it
Nothing to get out of them
Sure it's hard for them being the way they are
Being that way
But anyway, you have to admit it's not our fault.

- But that's just it. It is our fault.
That's just it. The fault is YOUR fault.
What? Men come and go along the corridors that you built for them, where you didn't bother to provide a single bench for them to rest on, where you crystallized a slew of scarecrows that viciously smack them in the face, where they hurt their faces, their chests, their hearts.
Where they find no space
Where you make no space for them
Where there is absolutely no space for them
And you dare tell me that it's not your problem!
That it's not your fault!

What? This man whom you thingify by systematically calling him Mohammed, whom you reconstruct or rather dissolve on the basis of an idea, an idea you know to be despicable (you know full well you are robbing him of something; that something you were willing to forsake everything for not so long ago, even life); well? Do you not get the impression that you are emptying him of his substance, this man here?

Why don't they just stay home!

Ah yes! In here lies the drama: why don't they just stay home. Except, we told them they were French. They learnt it at school. In the streets. In the barracks. (Where they were given shoes that fit them). On the battlefields. We introduced France to them everywhere, to any space in their bodies and "souls" that had room for something apparently grand.

Now, we tell them in no uncertain terms that they are in "our" country. That if they're not happy, they should just go back to their Kasbah. For here too there is a problem.

Whatever the trials he may go through in France, some believe, the North African will be happier at home.

In England, it has been shown that perfectly well-fed children, each with two nurses entirely at their disposal yet living away from their families, showed a morbidity twice as important as those less well fed who lived with their parents. Without going to such lengths, think of all those who live a life with no prospects in their own countries and refuse better positions abroad. What are good prospects worth when they do not culminate in a family, in a thriving home?

Psychoanalytic science considers expatriation to be a morbid phenomenon. In which it is perfectly right.

We can conclude from these considerations that:

1. The North African will never be happier in Europe than at home for he is made to live without the very substance of his affectivity. Cut off from his origins and cut off from his ends, he is a thing cast into the mayhem, bowed beneath the law of inertia.
2. There is something obviously and abjectly disingenuous about this statement. If the standard of living (?)[7] available to the North African in France is greater than the one he was used to back home, it means there is still plenty to be done in his country, in that "other part of France."

That there are buildings to erect, schools to open, roads to forge, hovels to demolish, cities to raise from the ground, men and women, children, and more children to adorn with smiles.

This means that there is work to be done over there, human work. In other words, work which is the meaning of home. Not of a room or of the barracks. This means that throughout the French nation (the metropolis and the French Union), there are tears to dry, inhuman attitudes to combat, expressions like *mon z'ami* to render unconscionable, men to humanize, streets like rue Moncey[8] to open to circulation.

Your solution, sir?

Do not push me over the edge. Do not force me to spell out what you should already know, sir. If YOU do not call forth the human that is before you, how am I to assume you call forth the human that is in you?

If YOU do not want the human that is before you, how am I to believe in the human that may be in you?

If YOU do not demand the human, if YOU do not sacrifice the human that is in you so that the human on this earth can be more than just a body, more than a Mohammed, by what sleight of hand might I acquire the certitude that you too are worthy of my love?

Notes

* First published in *L'Esprit*, February 1952.

1. Derogatory names used for North Africans.
2. Cf. Social Security? We're the ones paying for it!
3. Dr. E. Stern. "Médecine psycho-somatique" in *Psyché*, January–February 1949, p. 128.
4. My emphasis (FF), p. 20.
5. My emphasis (FF), p. 20.
6. TR: thieving like an Arab.
7. TR: (?) appears in the original text published by Maspero in *Pour la Révolution africaine*, 1964. I took it to be Fanon questioning the very notion of standard of living in a kind of personal shorthand, but it's open to interpretation.
8. A street in a poor neighborhood of Lyon where many North Africans live.

03_Fannon_cha01.indd 50 10/7/2014 5:37:27 PM

Chapter 2

Mental Disorders and Neurological Disorders*

This is certainly one of the trickiest questions that neuropsychiatrists have had to address over the past 20 years. Despite the fact that it was already extensively debated last century, the issue had not yet become such a doctrinal stumbling block. Responsibility lies in the powerful push toward specialization today and the subsequent urgency of establishing borders. What are the respective limits of Neurology and Psychiatry? Is there such a thing scientifically as the neurological and the psychiatric? What is a neurologist? What is a psychiatrist? What is to become then of the neuropsychiatrist?

Far from providing a solution here—we believe a whole life of study and observation would be needed—we would like to outline the positions of the most representative doctrinarians today: in France, Henri Ey and Jacques Lacan, and the foreigner, Kurt Goldstein. We should add that Ey follows the Jacksonian tradition and Goldstein, whose work presents many common points with Monakow and Mourgue's, finds a worthy defender in Ajuriaguerra.

This attempt at clarification seemed to us a useful exercise. Firstly, it can only facilitate the development of our own theoretical position in regard to the object: Neuropsychiatry. Finally, this study is worthwhile for the particular context of our work since the causes of psychical disorders linked to Spinocerabellar Hereditary Degeneracy are entirely unknown.

The Position of Henri Ey

Henri Ey's work is undoubtedly the most dense of the above founders. His numerous works, preparatory conferences for the medical admissions exam, and consultations, have made him a figurehead. We will obviously only be able to give a very systematic summary of his ideas. We apologize to the author. However, we

04_Fannon_cha02.indd 51 10/7/2014 5:37:56 PM

will attempt to formulate clear ideas without forsaking the spirit of the doctor of Bonneval's work.

For Ey, the nervous system is divided into two "planes":

1. The plane comprising sensory-motor and elementary or instrumental psychical functions (the system of reflexes coordinating movement, regulating tonus, walking . . .)
2. The plane comprising superior or energetic psychical functions (e.g., remembering, judging, believing, and loving)

The instrumental functions are specifically and morphologically inscribed in the brain. The main object of study here is the morphological and spatial genesis of the neural functions that constitute relational life, organized according to the notion of cerebral localization of the functional systems. The energetic functions are more personal and plastic modes of activity. The main object of study here is the historical and chronological genesis of the psychological levels that constitute relational life, organized according to the notion of psychological tension.

We find these two planes again in regard to pathologies:

1. Pathologies of the functional instrumental plane, identified as functional or local disintegrations. An extremely important element on this level is the localization of the disorder. We will see that the same does not go for global dissolutions. The following are characteristics of functional disintegration:
   - They are partial: hemiplegia, aphasia;
   - And basic: in other words, they leave intact the overall and superior structures.

   For, as Ey says, "the most typical forms of aphasia such as chorea, hemispasms or Parkinson's syndrome are bothersome but they do not as such and alone alter the consciousness, judgment and social activity of the subject."[1]
2. Pathologies of the functional energetic plane. Localization is impossible here as the main characteristic of these disintegrations is that they are generalized. The whole personality participates in the illness. Hence the second notion of dissolution applies here.

> Ey defines Neurology as the science of the instrumental plane and Psychiatry as the science of the energetic plane.
>
> These various points that Ey formulated during the 1942 *Journées de Bonneval* continue the doctrinal line of their author.[2] Some 15 years ago, Ey and Rouart established the initial grounds for an organodynamic conception of neuropsychiatry. Taking up the theories of Hughlings Jackson, they listed the factors of insanity so thoroughly examined by the English neurologist. Insanity being the object of psychiatry, it is key, Jackson says, to distinguish four original factors:
>
> a) The different depths of dissolution of the highest cerebral centers.
> b) The different people who have been subjected to dissolution.
> c) The different speeds at which dissolution occurred.
> d) The influence of differing states of the body and different external circumstances on the people who have been subjected to dissolution.

04_Fannon_cha02.indd 52 10/7/2014 5:37:57 PM

Jackson classifies local dissolutions as the object of neurology.

We do not wish to reproduce in detail the tenets of Jacksonism here. We know that the dissolution curve goes from illusions and abnormal emotional states to dementia, from dreams to schizophrenia via the epileptic crisis. Ey retains Jackson's most basic elements in his doctrine, notably:

Evolution—A hierarchy of functions—Dissolution

These three points represent the infrastructure of a crucial phenomenon: integration. The pathology that causes disintegration gives rise to negative signs (due to the illness itself) and positive signs (the part of the personality left intact).

In sum, Ey believes that the distinction between total and partial dissolution is "the only possible distinction between the objects of Neurology and Psychiatry respectively." This statement is significant for Ey's thought. Jackson's reflection centered upon the dialectic between Man and World. Ey, by introducing structural dynamism, attempts to formulate the major tenets of a dialectic between Man and Thinking. The neurological is localizable, spatial, instrumental, and elementary. The psychiatric is non-localizable, historical, global, and synthetic.

Yet the Psychiatric is not the Psychical. There is no psychical causality for mental illness.but an organic dynamism that lies at the origin of psychoses. And, says the author in his neo-Jacksonian catechism: "A dynamic conception of mental illness entirely based on the notion of functional dissolution requires that we link structural levels with the organic disorders that necessarily condition both minor neurotic dissolutions and delirious-confusional demented states. The main aim of the medical science known as psychiatry is to link the 'states,' 'syndromes,' 'structural levels,' or 'psychoses' to etiological processes."

So, the neurological is about the partial, the psychiatric about the global. After having determined the lower limits of psychiatry,[3] Ey attempts to explicit the upper limits. And the problem of psychical causality is thus posed. Does a mental illness, psychosis, or neurosis have a psychical origin or is it necessarily organically conditioned? In the case of coexistence between neurological and mental disorders, is it a personal reaction to psychical inflation or must we simply see in it an extension of lesions to the brain?

There is no psychical causality for mental illness. This is Ey's first doctrinal affirmation. Anticipating the reaction of his adversaries, who could easily throw a fist full of psychically conditioned psychoneuroses at his face, the author takes the case of a powerful emotional reaction whose effect is to turn hair white. "This symptom, he says, should not be attributed to the emotion that is the occasional psychogenetic aspect of the process but to a much deeper endocrinal disruption."[4]

Having discarded the theory that makes emotion the cause of pathology, the author successively examines the three other psychogenetist schools founded by Kretschmer, Freud, and Babinski. The first, thoroughly analyzed in Lacan's thesis,[5] sees delusion as the reaction of a consciousness "sensitized" to the vital situations in which it finds itself.

The Freudian perspective overlaps with and surpasses the previous one. While the psychiatrist, Kretschmer, attaches fundamental importance to predispositions

and constitution, Freud scotomizes them. Much later, in response to sometimes malevolent criticism from his adversaries, the Viennese master recognized the role of heredity and predispositions.[6] The notion of terrain was born.

Ey reproaches Kretschmer for limiting psychical causality to the idea of constitution. In addition, he finds an argument in favor of his critique in the evolution of dementia linked to schizophrenic dissociations. If there is dementia, it is because at some point there was an organic lesion. As for Babinski, Ey denies any value to his doctrine by claiming he was a dualist. We know the importance of suggestion in Babinski's system. For him, mental illness takes place on an ideational plane, which means, in effect, pithiatism. Everything else is a function of localizable neurological processes.

The foundation of the Freudian doctrine is put into question: psychical trauma is but an antiquated monument, the architecture of which does not let on to what usage it was destined... Infantile regression is presented as a literary cliché. For Ey, "any genetist and dynamic theory of psychical activity leads to the notion of normal psychogenesis and repudiates any notion of pathological psychogenesis." Which means that psychogenetic activity is a normal and free activity.[7]

And thus is revealed the psychiatricidal dilemma.[8] First the psychogenetist theory that holds mental illness to be an exclusively psychical creation; next the mechanistic theory that situates mental illness in a localizable region of the brain. Delusion is the product of the excitation of nerve cells. The author refuses to come out in favor of either spiritualist dualism or materialist monism as he says: "We reject both a dualism that over-separates and a monism that doesn't separate enough." Ey's whole position can be summed up in this phrase: "Between the physical and the social is life." Ey refuses to choose between the physical and the psychical, the mind and the body. For him, "psychical life is rooted in organic life; it feeds on it, uses it, *integrates* it and consequently surpasses it."

Speaking of the psyche, the author adopts the conclusions of various schools and writes: "Little by little, the structural whole that will become the object of study of psychology and psychopathology, is taking shape." We must distinguish between what is given and what is taken, the passive and the active in the psyche. Character and affectivity should also be noted and closely related to the "instrumental" functions (the sensorial, memory, and verbal capacities of each individual.) Ey calls this the *psychical trajectory*. This trajectory supposes a field to travel through which is the psychical field. The psychical field naturally refers back to psychical life which is in no way endowed with immutability. It "oscillates between disinterest in the outside world and the present, and supreme adaptation to the present and the real in its most attentive and efficacious form." We can see how much this statement owes to Janet's research. In fact, Ey recognizes the influence of the theoretician of psychological tension on the direction of his own thinking. Psychogenesis is normal. The corollary to this position is the existence of an organogenesis of mental illness and that psychiatry, refusing to see any value in the concept of pathological psychogenesis, delimits an area of study with no relation to the notion of freedom.

But then, what difference is there between schizophrenia and general paralysis? Ey says if an illness is always organic in its etiology, it is always psychical in its pathogenesis. "It is a mental alteration of organic kind."[9,10] What is the master

04_Fannon_cha02.indd 54 10/7/2014 5:37:57 PM

of Bonneval's position on our specific case? The mental disorders found in cases of Spinocerabellar Hereditary Degeneracy must not be understood as the reactions of a personality to the production of a valorizing unconscious. The character shifts and personality disorders are related to organic alterations brought on by the disease itself, no matter what level we situate them on.

The Position of Goldstein

There is a difference between the Hormé school and the Gestalt school. The reflex act, held by Monakow and Mourgue to be a metameric reaction, becomes with Goldstein a total reaction by the organism. Because, says the author, it is inadmissible that one part be capable of a reaction without the other parts being involved. There are no primitive functions on the one hand and higher functions on the other. Every gesture, every function requires the collaboration of the whole individual.

Patient Sch...with an occipital lesion had both calcarine rami destroyed. Goldstein and his partner, Gelb, after minute observation, were able to show that it was not aphasia—a term too easily attributed—but rather the incapacity to place oneself in a particular frame of mind. They ascribed this disorder to a failure of the symbolics of categorization.

When examining the root of the problem causing discord amongst contemporary neurologists, it appears that cerebral localization is the only really contentious matter remaining. But behind the desire to localize or not, we can surely distinguish the deeper question of the relationship between body and soul. To the superficial mind, it might seem as though the mass of publications and systems that have come out these past 50 years are more a reflection of impotence than of effective progress. The same is true of the skepticism toward therapy due to the large number of "inoffensive" special cases of illnesses that has taken hold of more and more doctors and by proxy, the public. It must be said that only a passionate and often arduous quest would allow one to intimate, overcoming discouragement, the hope of an organizing principle within madness, the hope of what Lacan calls the Logic of Madness.

Goldstein takes the work of Monakow and Mourgue and attempts to give it scientific value. The success of Gestalt theory proves that he did not fail. We will now provide a quick overview of the various points the authors developed in *L'Introduction biologique à l'étude de la neurologie et de la psychopathologie* [*A Biological Introduction to the Study of Neurology and Psychopathology*]. We will also use the independent work of C.V. Monakow in which the system is philosophically situated. Monakow believes it impossible to arrive at cerebral localization through scientific reasoning. "Psychical phenomena cannot be spatially localized." He situates the biological and psychological evolution of man on a temporal scale. Therefore there is no seat to the soul; extension is not the opposite of thought and neither is the soul the opposite of the body. On the contrary, any focal alteration can cause disorders in areas far removed (diaschisis). In addition, the body is not abandoned to itself. It is taken up again and valorized by a primary principle: the Hormé. This leap must be forgiven, as we did not want to pass over in silence the link between Monakow and Bergson.

04_Fannon_cha02.indd 55 10/7/2014 5:37:58 PM

The Monakowan *Hormé* can, in certain respects, be identified with Bergson's *élan vital* [vital impulse].

For Monakow, Man is fusion with Nature to the extent that the Hormé predominates. We are attached to Monakow's doctrine for one reason: man is man insofar as he is entirely turned toward the future. We will have the occasion, in a book we have been working on for sometime, to approach the problem of history from a psychoanalytic and ontological angle. We will then show that History is nothing but the systematic valorization of collective complexes.

C. V. Monakow's biology is about genesis and chronogenesis. For Monakow, the sphere of instinct takes precedence over the sphere of orientation: instincts are at the service of the Hormé. Pathology comes from an inversion of this relationship. In the case of attack, syneidesis comes into play in order to attempt to restore calm. For Monakow, there is not one but several souls. Every cell is endowed with consciousness, with a consciousness differential. Every vital phenomenon is taken as having a soul: the opposition between soul and body is thus overcome. The soul and life are identical.

With Goldstein, a gigantic step is taken in dealing with the question. Evolution and Dissolution, Jacksonian Integration and Disintegration, Syneidesis and Monakowan compensation are abandoned. For Goldstein there is no absolute local symptom. Every organic manifestation has a special tonality, the fruit of global mechanisms. For him the organism works as a whole. The aphasiac is not just a man that no longer speaks or whose language is altered. He is a new man. Aphasia is the dominant process, but it is important to take into account the background processes of the aphasiac man. These theories were developed in France by Ajuriaguerra and Hécaen in the critical study they completed of Henri Ey's doctrinal position.

By attaching too much importance to the symptom, H. Ey skews the problem. The symptom must not be valorized. Guillain and Barré showed, for example, that a patient lying down on his back can have a plantar reflex response in extension. The same patient will have a flexion response once placed on his front with his legs flexed against his thighs. This means that the symptom cannot be taken as fixed. Life in an undifferentiated state found in Ey's work is given organizational value with Goldstein. Cannon, in *La Sagesse du corps* [The Wisdom of the Body], described the sometimes arduous struggles that an organism will undertake in order to maintain health. Goldstein comes close to this with his notion of vigilance, which he in fact inherits from Head. For him neural energy is constant. As soon as one function is threatened, the others come to the rescue.

Studies on the spontaneous correction of hemianopsia are quite conclusive. For example, "When, by measuring vision, the retinal areas still capable of receiving light stimuli in a hemianopsic patient are identified, we notice that only two half retinas work. We would consequently assume that his visual field corresponds to one half—right or left depending on the case—of a normal visual field, with a peripheral area of clear vision. This is not so in reality. The subject has the impression that he cannot see well, but not that his visual field has been cut by half. This is because the organism has adapted to the situation caused by the illness by reorganizing the working of the eye. The ocular globes shift in order to present an intact part of the retina to light stimulus, whether originating from the right or the left. In other words

04_Fannon_cha02.indd 56 10/7/2014 5:37:59 PM

the preserved retinal area, instead of remaining poised for the reception of light rays emanating from one half of the visual field as it was before the illness, has now taken a central position in the eye socket. If we keep to the classical conception that links the perceptive functions of each point of the retina to its anatomical structure, and for example, to the proportion of cones and rods, then the functional reorganization that takes place in the case of hemianopsia remains incomprehensible. It can only be understood if the properties of each retinal point are assigned to it, not by any pre-established local apparatus but by a flexible distribution process comparable to the distribution of forces within a drop of oil suspended in water." (M. Merleau-Ponty, *La Structure du comportement*, pp. 48–50. [*The Structure of Behavior*])

Ajuriaguerra and Hécaen contest the existence of elementary and synthesizing functions. They stress that lesion and function are not the same thing. "If we were referring to the level of lesions, there would only be quantitative differences between disorders said to be elementary and disorders of the energetic functions... Why then assign different values to processes that are only differentiated by the severity of the lesion?" The opposition between elementary phenomena and the synthesizing apparatus does not hold. "It is the organization of the organism that imparts greater or lesser value." For Ey, the localizable is Neurological and the global is Psychiatric. Hécaen and Aujuriaguerra, on the contrary, go out of their way to prove that neurological disorders are also global. Here are a couple of cases discussed by the authors:

- Obs. I—A brain tumor causes hemiplegia in a young woman of 28. She denies her menstruation, does not recognize her bloodied sheets as her own and has no idea where the spots of blood might have come from. There are no other signs of mental disorder. Later she develops delusions of negation: her whole body is putrefying and later, she declares that her body has entirely disappeared.
- Obs. II—A woman of 33 develops hemiplegia of her left side: she too denies her menstruation, acts childishly, and speaks of herself only in the third person. That is all for Ey's first point.

As for the problem of the psychogenesis of psychoneuroses, what approach do the Gestaltists take? They say that pain and paresthesia can be revealed or caused by mental states alone. Without going so far as to claim that trigeminal neuralgia might by purely an outcome of psychogenesis, Wexberg believes that a particular psychic state can, by its presence, complete the series of conditions necessary for the appearance of this facial disorder by way of the autonomic nervous system. The conclusions of Professor Dechaume are close in kind. He recently wrote: "It is at the very least paradoxical that it is not the cerebrospinal nervous system, said to regulate relational life, that is the main instrument here. It is in fact the autonomic nervous system, which regulates animal life and that the Ancients used to hold responsible for coordinating the viscera, that ensures the unity of the human person."[11]

Pain, adds Ajuriaguerra and Hécaen is psychical. It is a whole and its significance is entirely a function of the individual subjected to it. How could we not recall the beautiful book by Professor Leriche on pain, and especially his last works: *Chirurgie discipline de la Connaissance* and *Philosophie de la Chirurgie.* [*Surgery as Discipline of*

Knowledge and *The Philosophy of Surgery*] In fact, the surgeon of pain did adopt the notion of totality since he says: "For us, the patient remains a puppet whose every string produces a specific movement, whereas in reality, in the act of living, everything takes place in the whole" (*Chirurgie discipline de la Connaissance*, p. 337).

For the Gestaltists, the neurological and the psychiatric go hand in hand. Neurological and psychiatric disorders are imbricated. The reverberation of a neurological event is not "limited;" it no longer simply creates an aureole but rather disrupts the whole personality. We are dealing with an individual profoundly altered in his ego.

To conclude, Ajuriaguerra and Hécaen committed a serious extrapolation in our opinion. They attempted to draw clinical conclusions from a starting point in phenomenological research. We think like Ey that: "what defines their position seems to be less a manifest concern to conceptualize neurological phenomena such as global disorders than the real tendency to reduce the psychiatric to the neurological." Insofar as Hécaen and Ajuriaguerra base their doctrine on the schema of the body and its alterations, they disregard the purely psychogenetic side of the question. Before wrapping up this quick review of the literature, we would like to mention another theoretician, J. Lacan, who has been able, in a minimum of articles, to provide a vigorous argument on the problem of the psychogenesis of mental illness.

The Position of J. Lacan

"Loin donc que la folie soit le fait contingent des fragilités de l'organisme de l'homme, elle est la virtualité permanente d'une faille ouverte dans son essence."
"Loin qu'elle soit pour la liberté 'une insulte', elle est sa plus fidèle compagne, elle suit son mouvement comme une ombre."
"Et l'être de l'homme non seulement ne peut être compris sans la folie, mais il ne serait pas l'être de l'homme s'il ne portait en lui la folie comme la limite de sa liberté . . ."
". . . Un organisme débile, une imagination déréglée, des conflits dépassant les forces, ne suffisent pas à faire un fou."

J. Lacan (La Causalité Essentielle de la Folie)[12]

["Therefore, far from being contingent to the fragilities of the human organism, madness is the permanent potentiality of a fault, open in its essence."
"Far from being 'an insult' to freedom, it is her most faithful companion; the one shadows the other's every move."
"And not only can man's being not be understood without madness, but it wouldn't be man's being if it didn't carry within it madness as the limit of its freedom . . ."
"A feeble organism, a derailed imagination and overpowering conflicts are not enough to make a madman."]

Few men are as contentious as Jacques Lacan. We could parody the well-known expression and say: "Amongst the psychiatrists, there are his partisans and his

adversaries." But we would also have to add that his adversaries far outnumber his supporters... which does not seem to especially bother the logician of madness. This coupling, though semantically unacceptable, does express a certain reality. Personally, if we had to define Lacan's position, we would say that it is a fierce defense of the rights of Madness to inhabit man.

In order to determine the contours of Lacanian thought, we found it useful to highlight the main ideas of his thesis. Two elements appear key to Lacan's analysis of the personality. These are: a) relations of understanding that he inherits from Jaspers; b) intentionality.

a) Relations of understanding, the criteria for psychological and psychopathological analysis, represent the common measure of human feelings and actions likely to be found in reference to a participationist interpretation.
b) Intentionality. Expressed through intentional phenomena, it reveals personal development through each of its manifestations.

What is important in Lacan's thesis is the subsumption of the characteristics mobilized in his definition:

A) Biographical development and the relations of understanding within it (Erlebnis)
B) A concept of the self (Ego Ideal)
C) A certain tension within social relations (Ego—Other)

We will see that Lacan remained faithful to this general framework. It seems to us that the value of Lacan's work hinges upon his definition of desire. He sees it as a behavioral cycle characterized by certain general organic oscillations, said to be affective, a more or less regulated motor agitation, fantasies the objective intentionality of which are more or less adequate depending on the case.

When a given life experience, active or passive, has led to affective equilibrium, a rest position and the disappearance of fantasies, we say, by definition, that a desire has been fulfilled and that this experience was the end and object of that desire. In his detailed analysis of the Aimée case, it becomes clear that Lacan sees psychosis as a behavioral cycle. As such, it is not a question of undertaking a study of the symptoms of psychosis like Kraeprlin and Bleuler do, but of grasping the organizational mechanism of desire and its fulfillment.

We believe there are traces of the influence of Paulhan's work, *Socialisation des tendances* [*The Socialization of Tendencies*] in Lacan's thinking, although he does not cite it directly. Indeed, the life experience that constitutes the aim of desire is essentially social in its origin, practice, and meaning. "Recognizing in morbid symptoms one or several behavioral cycles which, no matter how anomalous, display a concrete trend that can be defined by relations of understanding—this is the point of view we bring to the study of psychoses."

We noted earlier the considerable importance that Lacan attributed to the social. He expresses it in the three functions he ascribes to the personality under the attributes of comprehensibility, development, and idealism in the conception of self; and

finally, as the very function of social tension and of personality where the two attributes of the phenomena in fact engender each other. Lacan premises his doctrine on the postulate of psychogenetic determinism. This postulate supports a science of the personality; a science that has as its object the genesis of intentional functions which include human relations of a social kind. This is what he calls the phenomenology of personality.

Applying his method to self-punishing paranoid psychosis, Lacan highlights its value as phenomena of the personality by the coherent development of the delusion and lived experience of the subject, by its simultaneously conscious (delusion) and unconscious (self-punishing tendencies of the Ego Ideal) manifestations, by the dependence of psychical tensions related to social relations (tensions immediately manifested as much in the contained phenomena of the delusion as in its etiology and reaction formation).

Next to this phenomenological revelation of psychosis we can, with Lacan, distinguish three sub-characteristics which are in fact quite important:

1. A signification comprehensible in terms of the human.
2. The potential for dialectical progress: the cure being catharsis, a cure that represents liberation for the subject from a conception of self and world the illusion of which was held together by unknown affective impulses, and this liberation takes place as a run-in with reality.
   Note that spontaneous catharsis is not an entirely conscious process.
3. Openness to social participation.

The category of the social in human reality, to which we personally ascribe a great deal of importance, also captured Lacan's attention. He borrows the discoveries of the ethnosociology of projection, compiled by Mauss and Lévy-Bruhl, and describes the phenomenon of mandating. Certain images, he says (celebrities from the cinema, magazines, and sports) represent the need for spaces of the spectacular and moral communion typical of the human personality; they may take the place of rites, orgiastic or universalist, religious or purely social that represented them until now.

After having done justice to the absolutely mythic notion of constitution, in his opinion, Lacan discusses the limits of his work. Delusion becomes the intentional equivalent of an insufficiently socialized aggressive impulse. But what is interesting to uncover is the *concrete trend* underlying the intentional phenomenon which is the delusion. By appealing to Jaspers, Lacan distinguishes:

a) Delusions that appear as the development of a personality.
b) Delusions that present themselves as an eruptive psychical process that disrupts and reorganizes the personality. Only the examination of the genetic and structural continuity of the personality will show which cases of delusion are due to psychical processes and not development. In other words, which cases one should see as the intentional manifestation of an impulse that does not originate in infancy but is a more recent and exogenous acquisition, such that certain conditions like lethargic encephalitis prove their existence by demonstrating the primitive phenomenon.

04_Fannon_cha02.indd 60 10/7/2014 5:38:00 PM

Having dismissed the parallelist Tainian solution to personality, Lacan proposes a definition of delusion: "It is the expression in language, conceived for the purpose of rendering comprehensible relations amongst a certain group, of concrete trends whose insufficient conformity with the necessities of the group is unknown to the subject." We will see that this phenomenon of misrecognition is at the foundation of Lacan's thought. In the critique he makes of organo-dynamism, Lacan poses the question: does the originality of our object (Madness) stem from social practice or scientific reason?

Lacan seeks an answer to this question on both levels. Ey had encountered delusion in his structural analysis of madness. He saw it as a consequence of a deficit or lack of control. Delusional beliefs really take root from a "delusional intuition" (Dublineau). For Lacan, delusional beliefs are in fact misrecognition. We believe it is on this level that a reversal of Lacan's scientific approach takes place. By addressing the human value of madness,[13] the author moves from a question of causality to one of motivation. Speaking of knowledge and belief, he looks at madness from an intersubjectivist perspective. "Madness, he says, is experienced entirely in the register of meaning. And its metaphysical significance is revealed in that the phenomenon of madness is inseparable from the problem of signification for life in general, in other words, the problem of language for man."

We would have liked to devote many more pages to Lacan's theory of language but that would take us too far away from our present task. However, upon reflection, we recognize that all delusional phenomena is in the end expressed phenomena, meaning spoken. Hence the best way to analyze a delusion or abnormal psychical process is to be face to face with the explanation of the delusion.

A parallel between Ey and Lacan is hard to draw for the very good reason that the latter is attempting to define the logic behind the delusional act. Madness, says Lacan, is neither more nor less than a stasis of being.[14] Faced with the disorder of the world (which is the disorder of his own consciousness via trasitivism), the madman seeks to impose the law of his heart. Two possibilities present themselves. Either he breaks the circle by exerting violence on the outside, or he turns it against himself by way of the social backlash. This is the general formula by which madness operates. It can be applied to "any one of the phases by which the dialectical development of a human being is accomplished, more or less in everyone, and it is always realized as a stasis of being." The law of the heart that the madman wishes to impose is the price of freedom. The mad is no longer an alienated man, but one who has accepted to inventory all the abysses that freedom proposes.

By defining delusion as contingent upon loss of control or a deficit, Ey passes over the problem and therefore its solution. A person who kills in a fit of passion is not deficient since he is judged responsible for his act. There is meaning to the act that forensic medicine attempts to make explicit. Thus the idea of a deficit is not phenomenologically accurate.

To finish up, we would like to note the main factors of psychogenesis in the Lacanian conception. Taking a Jungian approach, which he does not cite, Lacan goes beyond the concept of the image, making the projection phenomena described by Lévy-Bruhl as a corollary of primitive thought, the cornerstone of his system. He

links the unhappy consciousness to a conception of magic. Internally then, Lacan seems to inhabit the meeting place of Hegel and Lévy-Bruhl.

Whereas for Jung the image was a projection onto the object of a subjective conflictual state or the second aspect of an ideal, it becomes with Lacan a general human likeness for the adult and a likeness full of intoxicating ingenuousness for the child. The author bases the story of psychical life on his mirror stage. It is the meeting of two bodies: the primordial Ego, ontologically unstable, and the existential complex engaged in a struggle within which Freud rightly distinguished the Death Drive. "In the beginning of psychical development, the primordial Ego as essentially alienated and the primitive sacrifice as essentially suicidal are linked." Thus, says Lacan, "there is an essential dissonance in human reality. And even if the organic conditions for intoxication are prevalent, one's freedom would still have to grant consent. The fact that madness only appears in man after the "age of reason" corroborates the Pascalian intuition that 'a child is not a man.'"

What kind of conclusion should be drawn from these various considerations? And, is a conclusion even necessary? Would it not be best to leave open a discussion that centers on the very limits of freedom, or in other words, the responsibility of man?

To finish up, we would like to mention a new trend in the human sciences: psychosomatic medicine. This science, based on the fundamental ubiquity of the nervous system and convinced that the sympathetic nervous system is in fact the real frontier, meaning the effective space of action shared by the organic and the functional, seeks to overcome the lesional versus functional disorder opposition in order to arrive at a holistic approach to the patient. The defenders of this theory base their position on anatomico-physiological and especially physio-pathological data.

"The *functional ailment* is a transitory disruption, a temporary anatomical modification, detectable with histo-chemical reversible techniques capable of *restitutio ad integrum* but also, if repeated and with multiple transitions, of becoming a lesion. The *organic lesion* is a definitive alteration, in constant evolution, often irreversible and self-sustaining in a kind of vicious cycle. The functional disruption can cause a lesion; it is not a disease that attacks individual organs but the whole organism: it is the morbid whole within the somatic whole." These initial points lead to the following remarks:

1. "The most localized visceral diseases can have psychical effects.
2. Mental illnesses can have effects and produce visceral somatic manifestations.
3. Finally, psychical causes alone can trigger and sustain the most authentic mental illnesses."[15]

We can see the implications of such conclusions. Yet the authors bring a maximum of precision to their position. From the gastric ulcer of psychical origin to emotional impotence through diencephalic schizophrenia, there is constant progression. One of the incontestable benefits of this new approach to medicine is that it resolutely attempts to reach the very heart of the human conflict. Pushing Jung's findings to the extreme, this trend proves that a medicine of the person is possible.

04_Fannon_cha02.indd 62 10/7/2014 5:38:01 PM

We could find this doctrine at fault for its esoteric character. Just as in psychoanalysis, a "singular" colloquium runs the risk of resembling confession. But are not all consultations invariably confessional? Is it not an appeal to the other, like Professor P. Savy claimed? And is the alleviation of pain the doctor brings by prescribing bismuth for an ulcer so very different from the kind brought to disheveled and stupefied consciousnesses, the likes of which only our civilization can produce, by reinforcing the bases of psychical synthesis? This method should certainly not be assumed to be an offshoot of psychoanalysis. Its proponents are absolutely opposed to the psychoanalysts. To the work of analytic dissection, they oppose the more esthetic synthesis. Psychoanalysis takes a pessimistic view of man. A medicine of the person makes the deliberate choice to be optimistic about human reality.

Notes

* Excerpt from Fanon's thesis, "Mental Alterations, Personality Shifts, Psychic Disorders and Intellectual Deficiency in Spinocerabellar Hereditary Degeneracy," defended on November 29, 1951. First published in *Information psychiatrique*, vol. 59, no. 10, 1975.

1. This is an idea that other authors such as Monakow, Morgue and especially Goldstein are absolutely against.
2. H. Ey, J de Ajuriaguerra, H. Hécaen. *Les rapports de la Neurologie et de la Psychiatrie.* Hermann et Co. Editeurs 1947 [*The Relation between Neurology and Psychiatry*].
3. As we can see, there is a clearly axiological approach here. It resembles the jacksonian hierarchy.
4. Lucien Bonnafé, Henri Ey, Swen Follin, Jacques Lacan et Julien Rouart. *Le problème de la psychogenèse des névroses et des psychoses.* Desclée de Brouwer et Co. Editeurs. [*The Psychogenesis of Neuroses and Psychoses*].
5. J. Lacan, *La psychose paranoïaques dans ses rapports avec la personnalité.* [*Paranoid psychosis and its Relationship to Personality*].
6. "Psychical causality is but a second degree causality; the psychical concept only acquires pathogenic value on certain terrains." Freud cited by Ey.
7. To understand the extent to which Ey is precise in posing the problem of the limits of freedom and madness, one must read *La Psychiatrie devant le Surréalisme.* [*Psychiatry and Surrealism*] The same end is valued differently depending on whether it is free or irreversible, whether it is flight or the consequence of a psychical weight on the organism. In the first case, we are dealing with a Poet, in the second, a Madman.
8. Ey's expression.
9. Volume IV of Ey's "*Etudes psychiatriques*" is called: *Les processus somatiques générateurs. [Generative somatic processes].*
10. Psychoses present pathologically original characteristics in that they constitute "anomalies in the evolution of psychical life under the influence of a—somatosis—"; anomalies that put psychical forces in play that organize "mental disorders," mental illnesses, "psychoses," and "neuroses," according to the laws characteristic of the level of dissolution corresponding to the action of the pathogenic organic process. H. Ey—*Etudes psychiatriques.* T. p. 44.
11. *Traité de médecine.* T. XVI, p. 1075.
12. TR: There is no such text by Lacan, David Macey tells us. *The essential causality of madness* is the subtitle to the second part of a paper called "Propos sur la causalité psychique"

[Remarks on Psychical Causality]. And these quotes are in fact from the third section of the paper, subtitled "Les effets psychiques du monde imaginaire" [The Psychical Effects of the Imaginary World] *Frantz Fanon: A Biography*. London: Verso, 2012, p. 138.

13. A psychiatrist from Lyon, M. Balvet, also took this approach, though we should note that their theses in no way coincide.
14. Lévinas suggests, on an ontological level, that inauthenticity is introduced into existence by way of a *Stasis of Being*. (Emmanuel Lévinas) *Existence and Existents*.
15. J. Dechaume, *Traité de Médecine T. XVI*, pp. 1070–1071.

04_Fannon_cha02.indd 64 10/7/2014 5:38:02 PM

Chapter 3

Aspects of Psychiatric Care in Algeria Today*

We found the decision to devote an issue of *lInformation Psychiatrique* to Institutions in French Overseas *Départements* particularly fortuitous at a time when Algeria is desperately in need of thousands of beds for emergency care, to respond to requests for repatriation of Muslims hospitalized in France, and now that yet another 200 hospital beds were requisitioned to handle the aftermath of the Orléansville earthquake.[1]

* * *

The problem of psychiatric care in the colonies was broadly addressed in the Reboul and Régis Report to the 22nd *Congrès des Aliénistes et Neurologistes* of 1912. The members of the Congress subsequently promised to define and implement the steps necessary for adequate provision of psychiatric care in the colonies.

In Algeria, however, implementing these recommendations would have to wait until 1932 when, under the impetus of *Médecin Général* Lasnet and Professor Porot, an active interest was taken in doing so. The decree of March 14, 1933, established the recruitment of physicians to psychiatric facilities in Algeria, calling upon physicians from metropolitan France. In addition, two orders issued on August 10, 1934, determined the operational structure of psychiatric facilities in Algeria: front-line units were created in the hospitals of Algiers, Oran, and Constantine and a Psychiatric Hospital in Blida.

The first were open wards with observational units while the second was to operate according to the provisions of the Law of June 30, 1838.[2] The implementation phase followed, and in July 1935, the open-door facility in Constantine was inaugurated. In his 1938 report to the *Congrès des Médecins Aliénistes et Neurologistes* held in Algiers, Henri Aubin listed the resources of Algeria:

Front-line units:
Algiers: 43 beds
Oran: 55 beds
Constantine: 62 beds

05_Fanon_cha03.indd 65 10/7/2014 5:43:11 PM

The Blida Hospital had a population of 1,000 patients at the time, which was already well over capacity. From that day forward, in his capacity as technical advisor for psychiatry, Professor Porot never ceased appealing for additional beds. He currently estimates a need for 5,000 beds and recommends the construction of psychiatric hospitals in the *départements* of Oran and Constantine. Unfortunately, his advice has not been heeded and the creation of psychiatric annexes in Aumale and Orléansville was less than satisfactory solutions from a psychiatric perspective and hardly made a dent in the overall need for beds.

Almost no additional construction has taken place since 1938 and so the situation in 1954 remains as follows:

Algeria has 10 million inhabitants: 8,500,000 Muslims and 1,500,000 Europeans. Psychiatry in Algeria is based on the following principle: front-line and second-line psychiatric facilities in each *département*. In the *département* of Algiers, the front-line is at the Mustapha Hospital (the Algiers medical school hospital) with 81 beds. Second-line care is provided by the Blida-Joinville Psychiatric Hospital with 2,200 beds, along with its annexes at Aumale and Orléansville with 300 and 200 beds respectively. The *département* of Oran, with its front-line at the Oran General Hospital, has a total of 545 beds. In the *département* of Constantine: the front-line, Constantine General Hospital, has 76 beds; the second-line consists of units in Bougie, Philippeville, Guelma, and Bordj-Bou-Arreridj with a total of 16 beds between them.

These psychiatric facilities are run by a single psychiatrist in the Oran *département*, one in the Constantine *département*, five in Blida Hospital, and one in Mustapha Hospital with the medical school clinic manned by Professor Manceaux and his interns. In other words, there are only 8 psychiatrists and 2,500 beds for a population of 10,000,000.

Moreover, in 1952, 536 Muslims were receiving treatment in Metropolitan hospitals. That leaves us with more or less 1 bed per 4,000 inhabitants. But if we factor in the fact that the Blida Hospital was designed for a maximum of 1,200 patients, with progressive overcrowding gradually reducing its efficacy, we are down to barely 1 bed for 7,000 inhabitants. It is not hard to imagine the kinds of problems a psychiatrist working under such conditions might encounter. In this study, we propose to demonstrate how difficult it is to provide decent psychiatric care at present, with illustrations from the admission, hospitalization, and discharge processes.

Admission

While admittance is obligatory in the Metropole for any patient endowed with a certificate of placement and order of admission, in Algeria, patients are received based on vacancies: either discharges or deaths. On September 23, 1954, 850 dossiers were pending at the Blida Bureau of Admissions:

European Females: 33
Indigenous Females: 141

European Males: 87
Indigenous Males: 583

These dossiers were sent from all three Algerian departments and their number continues to increase regularly. Many were constituted months ago, sometimes over a year. (Therefore, by the time a vacancy opens up the patient is sometimes already cured.)

Prolonged delays lead to the following situations:

a) Aggressive reactions from patients hospitalized too late;
b) Aggressiveness of the family toward the ill whose reactions are unpredictable;
c) Aggravation of a preexisting condition due to delayed care;
d) Minor scandals: sometimes patients brought to the emergency room are refused admission and left standing at the gates for long periods of time before having to return home to their families.

Patients judged for minor offenses that have been let off on medical grounds are nevertheless kept in prison awaiting hospitalization. Although the Prefect recently sent formal notice to the Hospital Director to prioritize these "medicolegal" cases—with delays lasting no more than a month—this measure can only be applied to the detriment of patients with sometimes more acute illnesses or requiring more specialized care.

The modalities of placement for the hospital are fairly uniform: admissions are almost always PO [placement by ordinance] given that only 136 of the 2,101 patients admitted since September 22 were VP [voluntary placement.] Of these, only 15 were privately funded. However, the process for free voluntary placement involves a complex administrative inquiry into the "financial and domestic situation of the ill" which is never completed in less than two to three months. The number of FVPs [free voluntary placement] however is on the rise due to the reclassification of POs who could not be accommodated immediately as FVPs, allowing them to be processed and inquiries finalized for admission.

Finally, a mainly administrative difficulty often arises with the admission of patients without precise identities (mostly from Morocco or the *Territoires du Sud*). These X or *SNP* [without family name] patients are later recognized by a matriculation number given on admission and a photograph.

Hospitalization

Because it was impossible to add extensions to existing Hospital pavilions, we had to make use of the smallest spaces, despite massive overcrowding almost double the regulation capacity for Blida. For instance, a pavilion for tubercular patients, built for 32, now houses 74; a pavilion for the "agitated," built for 44, now houses 106; a pavilion for difficult patients, built for 80, now houses 165, and so on... Thus a hospital that was built to house 971 patients now houses over 2,000. Almost all of

the dining halls and washrooms have been converted into dormitories, replaced here and there by makeshift installations that are far from adequate.

What kind of therapeutic activity can one hope to realize in a pavilion containing 170 beds? For 14 years, the doctors of Blida have been asking the Administration to build workshops and lounges. The Chapel, built 20 years ago, is not only used for worship—a priest visits once a month—but also as an ergotherapy workshop, a classroom for nurses, a movie theater... Similarly, the Mufti conducts prayers twice a month at the Mosque; it otherwise serves as a wicker and esparto-weaving workshop.

Many patients (those who do not have access to ergotherapy) have no choice but to linger in the courtyard after breakfast, as there is no lounge area. There are few places to sit aside from the ground and the Algerian sun is especially brutal during the summer...

Maintenance and housekeeping personnel have had to be considerably expanded:

Kitchen: 30 employees
Electricity: 8
Linen: 26
Painting: 19
Masonry: 19
Laundry Room: 20

The hospital can thereby function without outside assistance. The offices have also had to increase staffing to 26 employees. There are more than 280 employees across maintenance and administrative services alone.

Unfortunately, general service installations have not been likewise improved: the overburdened electrical installations are subject to frequent outages. These are all the more troublesome given that Hospital pavilions are heated electrically. An insufficient water supply means access is restricted to three hours a day during summer, causing grave inconvenience to patients, especially the incontinent.

However, the medical equipment available is quite satisfactory. All demands are met in a timely fashion and the Oversight Commission has practically never blocked medical expenses. The number of medical staff is significant and close to official requirements: 1 staff member for every 15 patients in calmer pavilions, 1 to 10 in admission and "agitated" patient pavilions. The total number of medical staff is approximately 820. A nursing school was also established this year. 120 staff members are currently enrolled with examinations programmed for December.

Because recruitment sometimes took place in rather exceptional circumstances, members of staff are alas all too often illiterate or only able to sign their names. Where there's a will there's a way, as they say, and fortunately, there is no shortage of goodwill. Every time an extra effort was required, the personnel responded with perfect spontaneity to our appeal. Little by little, even the most educationally deprived staff turned out to be of precious recourse in wards where there is so much to be done.

05_Fannon_cha03.indd 68 10/7/2014 5:43:12 PM

All the same, we did have to try to regulate hiring and so we now require a *certificat d'études* or passage of an equivalent examination. These measures were easily adopted thanks to the local medico-administrative team that has become increasingly aware of problems concerning the hospital as a whole. Thus the living conditions of patients have gradually improved.

Other improvements were made thanks to this collaboration. For instance, a weekly newspaper was inaugurated by patients with printing costs covered by the administration. Since the Hospital has no communal hall, we hold special events in the hospital pavilions—and to this end, carpenters and electricians are at the disposal of patients to help set up the stage, sound, lighting, and so forth. Similarly, traditional meals are served to patients on holidays observed by the Islamic faith.

Not only has the material contribution of the administrative and maintenance services peaked their interest in collective social events involving patients, but even the director and physicians took part in the opening of the Moorish café. However, all of this will be difficult to sustain unless a communal hall is built as requested by successive physicians for the past 15 years. The weekly film screenings take place in the chapel which is unsuitable both in terms of atmosphere and acoustics. Finally, we have recently managed to set up weekly excursions by bus to the seaside.

Discharge

The problems connected with release are particularly distressing, especially for Muslim patients. Release is already complicated by geographic factors, but it becomes insurmountably complex in the absence of any public or mental health policy. Year after year, for a hospital population that never ceases to grow with the addition of new beds, the number discharged either diminishes or remains stable. In the words of a 1951 report, the hospital is slowly but surely headed toward total asphyxiation. There are many reasons for this:

a) Patients transferred from front-line wards are carefully selected according to a scale based on the severity of resistance to cure. For the front-line wards, the BPH [Blida Psychiatric Hospital] serves as a hospice for the incurable.
b) Muslim patients in particular are only admitted to the BPH after their illness has progressed to a shamefully advanced or even dangerous state.
c) Muslims are reluctant to entrust their wives to hospital care.

If the above factors weigh heavily on therapeutic effectiveness, the following serve to impede the release of patients even when medically possible:

a) Islamic law, which permits instantaneous divorce and remarriage, is a source of insurmountable difficulties. After having been repudiated, women who are cured remain in hospital for months before they can be returned to the care of family, which, in the absence of precise information, must be sought without possible recourse to medico-social services.

b) Release into an unfamiliar environment is almost always doomed to failure. Beyond the fact that release into a Muslim environment is practically impossible, the problems of release into a European environment are so formidable that it is best not to attempt it.
c) Making contact with families hundreds of kilometers away or more is difficult. In the absence of local medical or paramedical centers, contact is made by administrative intermediaries.
d) Placing aged, feeble, or stabilized epileptic patients in hospice care is difficult and often fails, in part because of the traditionally sacred view of mental illness in Algeria.
e) For Muslims, preliminary release is an impossible dream without an infrastructure for the provision of psychiatric care, the ability to track the progress of social rehabilitation, or even to provide support to the patient.
f) These difficulties are twice if not three times as great for patients coming from the *départements* of Oran and Constantine. There are no modalities for cured patients to be transfered back to the hospital that first admitted them, which geographically speaking, would make much more sense in terms of resolving problems connected with release as they arise.

As early as 1940, Professor Sutter requested the provision of the following items from the central administration in a report to the Prefect, Mr. Gaubert:

a) Dispensaries for prophylaxis and post-hospitalization psychiatric care;
b) A social services center annexed to BPH;
c) Social workers to be assigned to patients after hospitalization;
d) A support group to help former patients of BPH.

We had to wait until 1954 before some of these concerns began to be addressed.

The Psychiatric Annexes

There are two annexes to the Blida Psychiatric Hospital, one in Aumale (120 km from Blida), the other in Orléansville (180 km from Blida). The pressing problem of demand and progressive congestion of BPH with patients who have more or less proven to be incurable, have made this makeshift easy way out possible in the absence of building projects adapted to ongoing therapeutic activities. Distributed in rudimentary fashion between the general hospitals of Aumale and Orléansville, they mainly absorb local patients while depending solely on Blida for medical expertise, which is more than three hours away by car. The *médecins-chefs* of Blida are required to visit the annexes once a month wherein, in the absence of local physicians or residents, they are required to take full responsibility for medical decisions. In practice, for the remainder of the year the annexes are left to the professional competence of

05_Fannon_cha03.indd 70 10/7/2014 5:43:13 PM

former section chiefs of the BPH who run them with personnel hired locally and with very basic psychiatric training.

After the Orléansville earthquake, its 200 patients were evacuated to Blida where some are still housed in tents. In order to provide these patients with real shelter before the winter, the Director of Health for the *Gouvernment Général* plans to relocate them to several new annexes to civilian hospitals in the region (while awaiting the construction of the Oran and Constantine Psychiatric Hospitals). And we may have to wait a long time indeed, notably for financial reasons.

Finally, there are certain administrative features that distinguish the Blida Psychiatric Hospital from its Metropolitan counterparts. For example: (1) the hospital's director is chosen from the ranks of civilian hospitals and does not therefore benefit from the same status as directors at Metropolitan psychiatric hospitals; their lack of psychiatric "specialization" is also an inconvenience. Although we must congratulate the current director on his competence and understanding, we should be concerned about the inevitable period of transition and adaptation with each new director. (2) During the annual leave of the director, or in case of absence, administrative services are entrusted to the bursar rather than to one of the *médecins-chefs*. (3) The *médecin-chef* of each ward must also serve on various boards and commissions. Experience has shown that these anomalies are not without issues, therefore we are resolved to make sure this hospital resembles a Metropolitan hospital as much as possible in terms of the matters noted above.

Conclusions

This study has shown that conditions in Algeria cannot be deemed "satisfactory" for the practice of psychiatry, much less the present organization of psychiatric care across the three Algerian *départements*:

On a local level, we hope that the Administration will finally take seriously the complaints expressed for over a decade and give more importance to psychiatric hospitals within the overall medical infrastructure. We hope to see the completion of this infrastructure, the reduction of overcrowding at BPH, thereby restoring therapeutic efficacy.

At the general level, the creation of psychiatric dispensaries and post-hospitalization services is urgently needed.

Above all, sufficiently large and rationally conceived psychiatric hospitals must be built in Oran and Constantine. By all indications, the key to the problem lies here—and physicians have been repeating it for some time. Although certainly the difficulties and resistances faced by the Administration, especially at the local level, cannot be ignored, it seems to us that the situation has become too grave to be content with remote and partial solutions.

Notes

* In collaboration with J. Dequeker, R. Lacaton, M. Micucci, and F. Ramée (Blida-Joinville Hospital) first published in *L'Information psychiatrique*, vol. 31, no.1, pp. 11–18, 1955.

1. TR: On September 9, 1954, a severe earthquake hit the area around Orléansville, killing approximately 1,600, injuring 5,000, and displacing about 10,000 people.
2. Known as the "*loi des aliénés*." Most well known for attempting to regulate internment by distinguishing between voluntary and involuntary placements on doctor's orders only, multiplying the number of psychiatric hospitals, and improving conditions for patients by creating opportunities for work within the asylum and defining the legal status of patients. Despite severe criticism, it remained in effect until 1990.

Chapter 4

Sociotherapy on a Ward for Muslim Men: Methodological Difficulties*

We have recently undergone a fruitful experiment as part of our attempt to organize a psychiatric ward for Muslim men according to the principles of sociotherapy. We would like to present this experiment for the consideration of our readers. We will lay out the difficulties we encountered without finessing them, and demonstrate that the lack of objectivity in our approach was the sole reason these errors were brought to our attention.

When we became aware of the double alienation, which results from the tyranny of subjectivity, and from what Piaget calls sociocentrism, we were able to entirely shift the orientation of our research. We submitted ourselves to the culture before us and cautiously but attentively engaged it. Wonderfully, the indistinct notes that had initially awakened our interest increasingly began to form a coherent whole.

The experiment we are about to relate was possible because there were both Europeans and Muslims in our division. What made this exceptional situation valuable experimentally was that the two groups were not mixed: there were 165 European women on the one hand and 220 Muslim men on the other.

We should recall a few particulars of the Blida Psychiatric Hospital. When we arrived, our four colleagues were responsible for the medical supervision of over 600 patients each. Under such conditions, any attempt to reorganize their wards on the principles of sociotherapy was impossible. With the arrival of a fifth physician, their load was lightened by 400 patients; only at this point was it possible to imagine the development of an authentic sociotherapy.

At Saint-Alban Hospital, we had observed the successful functioning of an institution which we believe, as a whole and in its details, realized the ideal form of a maximal sociotherapy within the present conditions of psychiatric care in France.

We therefore started with our division, taking it, in a sense as our experimental milieu.

06_Fannon_cha04.indd 73 10/7/2014 5:37:40 PM

We decided to hold biweekly collective meetings of the pavilion,[1] staff meetings, meetings around the newspaper; and bimonthly festivities. In the ward for European women, we did not have to wait long for results.

As early as the first month, the meetings became an integral part of life on the ward. They were held at fixed times and dates, and we placed great stress on our own punctuality in order to convey the importance we accorded to these meetings. Not only did patients and physicians attend, but also nursing staff, particularly at the beginning, as it was important that they understood the logic of our procedures. After a brief period of uncertainty, we were generally able to grasp the attention of our patients quickly and on the whole, a good feeling was created, and interventions from participants succeeded one another without long and awkward pauses. In the beginning, discussion focused mainly on minor incidents in the ward, but as the social architecture began to take shape, the possibilities of exchange around more concrete themes grew.

Christmas, with its deeply embedded traditions, provided us with an opportunity to instill a series of well-defined and intentional activities at the heart of the pavilion. A huge dormitory of 65 beds was emptied out. Male and female patients and nurses from the other wards flooded in. The medical corps and administrative services came in impressive numbers to attend this first event. Religious hymns, choirs, carols, a Christmas tree, and the Nativity Scenes carefully decorated by hands trembling with emotion: everything was done to ensure that the festivity proceeded with a maximum of solemnity.

When, during a collective meeting two days later, we proposed that patients organize regular festivities on their ward, we hardly encountered any opposition. Certainly, things were difficult in the beginning but today the small incidents that occurred have more or less disappeared: there was a period of disinterest and passivity on the part of the patients, and the nurses too, before they realized that the aim was not always to give center stage to the same delirious patient but rather to get the occasional catatonic patient to participate, or even the senile or sitophobic patients. Now this is understood, and we no longer participate directly in the organization of these events. Festivities are now planned, invitations sent out, and the stage is arranged by patients with the help of one or two nurses, and we attend merely as spectators. The event thus takes on a truly therapeutic character. For instance, anecdotally, when the paranoid patient responsible for the musical number—*Sombreros y mantillas*—kept watch on the catatonic patient out of the corner of her eye to make sure she wasn't losing the thread, pinching her when necessary to get her moving again.

Alongside the events committee charged with organizing festivities, there is also a cinema and a discotheque committee. The cinema should not merely be about watching a succession of images accompanied by sound; it must become the unfolding of a life, the development of a story. Thus the cinema committee gives true meaning to the fact of watching a film, by selecting films[2] and commenting upon them in a special column of the newspaper. Similarly, the discotheque committee organizes musical gatherings where it is possible to listen to Luis Mariano records as well as to *The Unfinished Symphony*—the latter accompanied by program notes written by a patient.

06_Fannon_cha04.indd 74 10/7/2014 5:37:41 PM

Two committees run *Notre Journal,* our weekly newspaper: an editorial committee which selects from the articles submitted, and a printing committee. The editorial is written by a member of the medical team, addresses particular issues, and provokes both patients and staff to consider the hospital in its totality. The articles by patients were rather monotonous in the beginning: "I thank the doctor for his good care" or "I'd like to leave soon." Now, even though the writing is too often signed by the same names, as a recent editorial pointed out, the newspaper otherwise reflects the progress being made: invitations to the next event or to listen to music; accounts of recent excursions or notice of forthcoming ones, promenades, films of the week, and more generally for all of those events of communal interest and value.

Finally, ergotherapy occupies an important place in the life of the ward and we are seeking ways of harmoniously integrating it into all of the activities. Aside from domestic tasks, one of the nurses runs a knitting workshop where several patients work together on a single piece. Other patients stitch and embroider tablecloths, napkins, and curtains. More recently, we have begun a dressmaking workshop to make dresses with fabric purchased by the patients themselves with their individual earnings. For patients who have been here for five to ten years, the importance of these things can be easily imagined: the flowered or striped fabric, bright or dark depending on each person's taste, breaking the monotony of the hospital gown. And let us not forget the ceremony of women trying on their dress, having to remain still while the expert hands of the seamstress do their work. The institution is thus too powerful, and the patient's attitude to her context cannot but be modified: she can no longer attend only to her madness without engaging with her surroundings.

The activities briefly described above form the fabric of an increasingly rich social life. We were able to organize it without too much difficulty because we had already experienced a convincing model. Thus from the first months in the European women's ward, we sensed the process working on the group, rapidly and productively. The atmosphere had palpably changed and we were able, theatrically, to remove all the physical restraints without fear of any major problems. Not only were the hardships of life in the asylum alleviated for many, but the frequency with which patients were discharged was already clearly on the rise.

* * *

This rapid and fairly easy success on the European women's ward only underscored the complete and total failure of the same methods on the ward for Muslim men. On examining one by one the various attempts we made, we can acknowledge them as a series of failures.

We knew that group psychotherapy would be more difficult for us among the Muslims, and we met with the patients only after several meetings with the nursing staff. The meeting was carefully planned. The table in the central dining hall was covered with a tablecloth and decorated with flowers. The intern, warden, and nurses accompanied the physician in order to increase the ceremonial value of the event. The most agitated patients were left in the courtyard. From the onset, it was difficult to establish contact because we did not speak the same language. We

06_Fannon_cha04.indd 75 10/7/2014 5:37:41 PM

sought to surmount this obstacle by choosing from among the Muslim nurses an intelligent, articulate interpreter to whom we carefully explained in detail what we were trying to accomplish.

During the hour-long meeting, we tried to gain the interest of all the patients—to transform an abstract, impersonal multitude into a coherent group animated by collective concerns. We spoke of events, films, the newspaper; rarely did we obtain silence. Quite oblivious to our presence, one patient continued with his motor stereotypies while another carried on his hallucinatory conversation; two others argued loudly with each other, while one left to lie back down in the courtyard. Very few realized the importance of our presence or agreed to enter into a dialog. The only one to be really engaged, too engaged, was a man suffering from persecution paranoia who spoke good French. Yet, far from leading his companions toward a group response, he more or less consciously sought to distance himself from them.

Confronted with this general disinterest, we were unable to find themes to address. The silences got longer, heightening the sense of unease. After a few weeks, the collective meetings that were originally meant to last an hour became progressively shorter. They now constituted an empty ceremony, absurd and devoid of meaning, so after some hesitation we decided to discontinue them for the time being.

We then tried something else, asking the nurses to each choose ten patients to meet with every night for an hour and to garner interest through discussions, games, or songs. We gave precise instructions, as the point of the exercise in our minds was to instigate cooperation and a team spirit of a kind that might reawaken their sense of sociability.

From the reports of these sessions written up each evening by the nurses responsible, we see, on the first days, notes such as:

> we met and played hide-and-seek, cards, and dominoes. A pleasant atmosphere, but this or that patient wasn't interested in the games.

And a little later:

> a game of *pelote cavalière*[3] was played by the following patients: . . . , assisted by attendant K. In the beginning the game seemed complicated but they were able to learn the rules and things went smoothly.

The following days, less and less time was spent on group games and the tone of reports became more pessimistic:

> we started with ten patients, but after ten minutes only six remained. M., N., B., and B. are relentless card players. B. and L. left to get some sleep on the pretext of being tired from all the work.
>
> patients O., M., S. N. P.[4], I. refused to attend the meeting, saying they were tired. The patients chose to play a game of dominoes; they were very pleased to play a quiet game without conversation.

Evenings were thus reduced to listening to classical Arabic music on the radio. Patients remained indifferent, and the nurses began to experience these meetings

as a chore. After some time and despite our repeated encouragement, the nurses expressed their lack of enthusiasm frankly: "There's no way to get the patients interested. As soon as they're finished eating all they want to do is sleep. We have to lock the dormitories in order to prevent them from doing so."

Alongside these "evening chats" we tried to organize a special event for the pavilion. We gave ourselves plenty of time as we knew it would be difficult. The show was to consist of a choral section and a theatrical number—however it was difficult to find even two nurses willing to take charge of the organization. After two weeks of rehearsals, we were down to an old PG left murmuring and shaking his head while the others stood silent. The nurses themselves weren't making much effort and, irritated by their lack of conviction, we told them they were not doing all they could, since what was possible in the European women's ward must also be possible in the Muslim men's ward. Thus they were not upset to be replaced by others, who failed as well. Still others had no more success, and when a last nurse who appeared for the job requested a transfer to another ward, we began to realize that this might not be simply a matter of laziness.

As our attempts to encourage the Muslim patients to organize recreational and theatrical events themselves had failed miserably, we sought to resolve the problem by "offering" them entertainment. Many patients went as spectators to the European women's events and attended the cinema regularly. Yet we noticed that if the pavilion chief forgot to send them over to the women's ward, no one came to inquire about it. And at the cinema, some left the chapel[5] in the middle of the film to smoke outside. Thus we had to recognize that we had failed in our attempts to organize collective meetings, recreational events, and the smaller group activities.

As for the journal that should have served to cement the social group, the Muslim patients remained outsiders: only one article was published over a six-month period. It turned out to be by the same paranoid patient who was upset that women were playing male roles. Only a few nurses from all the pavilions read it.

If we were unable to develop valid recreational or cultural activity, we were not much more successful in ergotherapy. Of course, there was already a workshop in the hospital mosque for manufacturing straw mats, baskets, and hats that employed a number of our patients. Others worked inside the pavilions or in general services. We could not attribute any particular therapeutic value to these activities, as tasks were assigned at random and patients accepted them as a distraction, to get away from the courtyard. They often worked only long enough to buy snacks or cigarettes, then refused to continue, alleging stomach or leg pains if need be.[6]

This is why we decided to create an ergotherapy workshop directly within the ward. To this end, we sent a nurse away for a month and a half, full time, for training in the details and skills of working with raffia. Upon return, some 15 patients, only those who were undergoing insulin treatment, were sent to him, where he was supposed to make them work for part of the morning and all of the afternoon. Yet, whenever we visited the workshop, we noticed that most patients remained unoccupied and completely indifferent to the completion of the communal project. Whenever the monitor had his back turned, they would get up and leave, preferring instead to help their companions outside on landscaping with pick and shovel.

06_Fannon_cha04.indd 77 10/7/2014 5:37:42 PM

Despite our repeated encouragement, no more than three baskets were made and we soon sensed that it was useless to expect anything more.

After three months and despite a great deal of effort, not only were we unable to interest Muslim patients in the beginnings of collective life taking shape in the European sector, but the atmosphere on the ward remained heavy and stifling. There was still a significant number of incontinent patients and, by the end of the day, hardly enough linen was left to keep them more or less clean. During meals, the noise in the narrow dining hall was deafening as the space was too small for the number of patients. Many seemed to take pleasure in throwing their food on the table or floor, bending their iron plates, or breaking their spoons.[7] Under these conditions, it is easy to see why the staff spent so much of their workday on cleanup.

The frequent fights between patients, which nurses had to break up at the risk of receiving blows themselves, sustained the atmosphere of mistrust on the ward. Nurses were afraid of patients and even the barber refused to shave patients unless they were restrained. Out of fear or desire to punish, patients were left in their cells—sometimes without shirt, mattress, or sheets—when they were deemed to be "shredders." As a preventative measure, these eternal "recidivists" were often tied up even before they had done anything. As Paumelle so aptly demonstrates[8], the same rhythm, the same vicious circle repeated itself: agitation, restraint, agitation, all reinforcing the penitentiary spirit of the ward.

Every new effort on our part to relax the punitive structure of the ward was received by the staff with impassivity and sometimes with outright hostility, disguised as irony: "This patient got agitated and struck that one or broke a window. What should we do? Restrain him or let him carry on?" We were powerless before the arguments of our "decorated" staff, consecrated by years of experience in the asylum: "You're still new to Algeria, you don't know them yet. When you've been here fifteen years like us, you'll understand!"

Thus, after only a few months, the contrast was striking. On the European side, the newspaper appeared weekly, theatrical performances were conducted regularly and agitation had disappeared. The atmosphere had become therapeutic. On the Muslim men's ward, on the other hand, we kept running into the same problems. The number of patients in restraints was still significant and there were no signs of improvement despite our many efforts. And gradually it became clear that this was not merely a matter of coincidence, laziness, or bad faith. We were on the wrong track and had to figure out the underlying reasons for our failure in order to escape this impasse.

* * *

In the meantime, we studied the Muslim men's ward in depth: both the character of the patients occupying it and the kinds of contexts they came from. We naively thought of our service as a whole, assuming that frameworks from a technologically determinate Western society could be adapted to a Muslim one. We wanted to create institutions and yet we forgot that any attempt of this kind must be preceded by a persistent, concrete, real inquiry into the organic foundations of the indigenous

06_Fannon_cha04.indd 78 10/7/2014 5:37:42 PM

society. What error in judgment led us to believe Western-inspired sociotherapy possible in a ward for Muslim *aliénés*? How was a structural analysis possible if we bracketed off the geographic, historical, cultural, and social contexts?
We propose two explanations:

a) First of all, North Africa is French—and if you are not looking for it, you will not see why approaches should differ from one ward to the next. The psychiatrist unthinkingly adopts the politics of assimilation. Natives do not need to be understood in their cultural originality. They are the ones who must make the effort to adapt and it is in their interest to resemble the kind of man presented to them as a model. This kind of assimilation does not suppose a reciprocity of perspectives: instead, one culture must disappear for the benefit of another.

Thus, aside from the need for an interpreter, our attitude was absolutely not adapted to the Muslim men's ward. In fact, a revolutionary attitude was essential—for we needed to move from a position where the supremacy of Western culture was self-evident to one of cultural relativism. Hence, we had to once again return to Piaget: his notions of adaptation and assimilation are key and we have only just begun to make use of them.[9]

b) Finally, we should add that those who preceded us in unveiling the North African psychiatric fact limited their scope far too much to motor, neurovegetative phenomena, and the likes. To our knowledge, though the work of the Algerian School revealed several particularities of the North African context, it did not proceed with a functionalist analysis that is clearly indispensable. A change in perspective was necessary; or at the very least, a follow-up to initial perspectives. In other words, we had to try to grasp the North African social fact. We had to insist upon the "totality" which Mauss viewed as the guarantee of an authentic sociological study. We had to make a major leap, and achieve a transvaluation of values. To speak plainly, we had to move from the biological to the institutional, from natural to cultural life.

The biological, psychological, and sociological were only separated by a kind of mental aberration. They were in fact indistinctly linked. It was because we had not integrated the notion of Gestalt or elements from contemporary anthropology into our everyday practice that we encountered such clear failures.

For example, during the six months that Muslim women attended events in the European pavilions, they applauded mildly in the European manner. Then one day, a Muslim orchestra came to perform at the hospital and we were astonished to hear them respond to the singing and playing with short, high-pitched, repetitive vocal modulations.[10] They were reacting to the specific configuration of the "ensemble," the grouping of relations, in accordance with the requirements of that ensemble. It became clear that we needed to find those ensembles that would facilitate reactions already inscribed within a definitively elaborated personality. Sociotherapy is only possible inasmuch as it takes into account social morphology and modes of sociability.

What are the biological, moral, aesthetic, cognitive, and religious values of this Muslim society? How does the native react from an affective, emotional standpoint? What modes of sociability inform the different attitudes of the Muslim?

We had before us institutions we did not understand: to what did they correspond? A functionalist analysis had to be undertaken in order to facilitate our task.

06_Fanon_cha04.indd 79 10/7/2014 5:37:43 PM

One of the writers has a work in progress on the complexity of North African society which is presently undergoing profound structural change.[11] However, it will suffice here to recall a few characteristics of this society.

Traditional Muslim society is theocratic in spirit. Aside from being a philosophical belief, the Muslim religion is also a way of life with strict rules of conduct that regulate both individual and group. In Muslim countries, religion permeates social life leaving no room for secularism. Law, ethics, science, and philosophy are all interwoven with religion. Alongside the properly religious, Islamic imperative, traditions inherited from the old Berber customs also play a strong role, which explains the rigidity of the social context.

It is also a gerontocratic society. The father governs family life and all the important matters must be addressed to him, or in his absence, to an older brother or uncle. Families, moreover, are quite extended, sometimes to the point where whole douars[12] share a surname! They tend to identify themselves with a clan, which is the natural social group in Muslim Algeria. Decisions are made by the Djemâ, a kind of municipal council chaired by a president, the importance of which the administration has only recently recognized. Until these past few years, there was no national community to speak of but rather an amalgam of familial, clan-based communities.

We should also point out the ethnic complexity of the region as the Kabyles form a significant minority amidst the Arabic population. The two groups are united by the Muslim religion yet separated by marked differences in language, tradition, and culture. Kabyles, of Berber origin, inhabit the mountainous regions. Their villages, perched on hilltops, are the spaces where tribal organization remains strongest. Arabs, by contrast, inhabit the plains and cities. They are mainly farmers, merchants, and craftsmen.

We do not have the space here to address other local specificities—the Nomads, Southern Arabs, Mozabites, and Chaouis—nor do we need to for our present purpose. Out of the 220 patients on the Muslim men's ward, there were 148 Arabs and 66 Kabyles, and only 6 Moroccan Chaouis and Mozabites.

Lastly, we should say a word about the living conditions of our Muslim patients, which largely explain their state of ignorance and traditional primitivism. Before the French conquest, land was communally owned and the notion of wealth was tied to the notion of useful, workable land and consequently to the possession of yoke or plow; the possessors of these tools were the real landowners.

The arrival of the French led to the transformation of landownership and redistribution of goods: the old communal land was fractioned off between possessors and later, private owners. The members of the old tribes lived a life of poverty but did not become proletarianized. Today, other than a small minority of big landowners (European and Muslim), there is a mass of small landowners (*fellahin)* who barely make a living from small plots cultivated with primitive farming techniques while they are still the envy of those left out of the redistribution entirely. The latter now rank amongst the destitute and their sociological ties to a collective tribal personality are gradually unraveling as they seek to sell their labor as *khammes*[13] or day laborers. A process of disassociation is at work in this previously homogenous

06_Fannon_cha04.indd 80 10/7/2014 5:37:43 PM

society between the small proprietors on the one hand and shepherds, *métayers* [sharecroppers], and day laborers on the other.

As a result of the increasing use of modern agricultural techniques by the big landowners, masses of unemployed agricultural workers are lured to the cities by hunger, while the absence of concomitant industrialization condemns them to the proletariat, if not the subproletariat, further accentuating the social disequilibrium. Furthermore, especially amongst the Berber population, many are those who move to France for a determinate period of time either to find employment they could not find at home or to complement a meager harvest.

This evolution of the sedentary population leads to a fracturing of the group and thus resembles the evolution of the nomad population. It is difficult to imagine nowadays the importance of ancient nomadic structures in North Africa: the southern tribes would travel all the way to the seashore; it was a periodic tide coming up from the sand and steppes and breaking across the highlands. The French occupation naturally brought with it a gradual regression in nomadism which can be summed up in two words: sedentism and the sale of labor (proletarianism). However, seasonal workers remain outside the sedentary group they come to help. The old nomadism maintained traditional authority and group cohesion while the new circulation of individuals taking place today operates outside of all tribal conventions and contributes to hastening a dangerous detribalization. The decline of the old nomadism is as inescapable as the rise of its replacement: proletarianization.

The factors precipitating the dissolution of both sedentary and nomadic groups also explain the formation of shantytowns on the outskirts of large cities, which not only defy the laws of aesthetics and urban planning but also constitute a grave sanitary and moral danger.

To illustrate the situation we examined the social composition of the Muslim men's ward:

Of 220 patients:

- 35 are fellahs: owners of small plots of land that they farm themselves
- 76 are agricultural workers, *métayers*, or day laborers
- 78 are workers (bakers, painters, etc.)
- 5 are intellectuals
- 26 have no profession

However, these numbers require interpretation. For instance, it looks as though a relatively large number of patients are workers (78 out of 220). In fact, they are mostly men uprooted from the countryside who took whatever manual work they could find regardless of their initial profession. Of the 78, only two-dozen or so are even minimally specialized in a trade. As for the 5 "intellectuals," they are all local schoolteachers with little more than an elementary school education.

These issues have far-reaching consequences. Although it is impossible to count the isolated cases of individuals who escape traditional society, their numbers are steadily growing. These elements are the forces driving the fragmentation of domes-

06_Fannon_cha04.indd 81 10/7/2014 5:37:43 PM

tic, economic, and political frameworks yet they remain poorly analyzed. This society, so often seen as fixed in its ways, is fermenting from the bottom up.

Though all too brief and requiring further development, these few notions sufficiently illustrate the specificities of Muslim Algerian society that we needed to integrate in our efforts to lay the groundwork for sociotherapy amongst Muslim patients.

* * *

We can now begin to comprehend the reasons for our failure. As we noted earlier, the pavilion meetings had not proven fruitful. This was mainly because we did not speak Arabic and we had to resort to two interpreters, one Kabyle and one Arab. The need for interpretation, in turn, fundamentally vitiated the psychotherapeutic doctor-patient relationship.

Under normal circumstances, patients have already run into the figure of the interpreter in their relations with administrative bodies or the justice system. Being faced with a similar need for an interpreter in the hospital spontaneously provokes the kind of mistrust that makes "communication" difficult. In fact, once the patient feels at ease, his discourse grows animated while vehemently trying to explain that he is cured and should be released immediately; so much so that he often forgets the presence of a third party and addresses us directly. He senses that the other cannot possibly convey with the same "feeling" what he is trying to express. It is easy to imagine how a study of this kind of three-way dialog might illustrate the disruption in the phenomenon of encounter.

The presence of an interpreter not only bothers the patient but also the physician, and, above all, the psychiatrist, who can only arrive at his diagnosis through language. In this case, there is no synchronicity of perception between the gestural and verbal content of language: facial expressions and gestures abound, but one has to wait until the end of the monolog in order to grasp its meaning. And then, the interpreter sums up in two words what the patient spent ten minutes describing in detail: "He says his land was taken away" or "his wife is cheating on him." Often the interpreter "interprets" the patient's thought according to formulaic stereotypes that strip it of all content: "He says that he hears djinns," but we can no longer tell if the delusion is real or induced.

Thus the use of interpreters, while perhaps valuable for explaining something simple or transmitting an order, is entirely useless when engaging in dialog; and only dialog, the dialectical exchange of question and answer, is capable of overcoming reticence and making apparent abnormal, pathological behaviors.

Yet as Merleau-Ponty says, "to speak a language is to carry the weight of a culture." Not speaking Arabic, we could not know which elements of their cultural or affective heritage might gain their interest. Hence, with the European women, it was easy to begin discussion on a record by Tino Rossi or a film by Fernandel. With the Muslim men, discussions were always cut short because we did not know what to talk about.

Similarly, given a little hindsight, our attempts at organizing special events appear quite naïve—for the very notion of festivities other than familial or religious

events is quite abstract to the Muslim. In addition, collective celebrations seem to differ fundamentally in content from Western festivities. It was difficult to get a chorus together because Muslim men dislike singing in groups; one does not sing at home out of respect for the father or elder brother. And we were not able to find a single person amongst the Muslim nurses willing to sing or perform on stage either. Similarly, theatrical pieces were not performed firstly because theater as we know it does not exist in North Africa and secondly because performing in front of others is not done. Although Arabic theater certainly exists today in the big cities, it is quite recent and has not spread to the wider population. Actors and singers are professionals who remain outside the social group. In the villages or douars, there are itinerant "storytellers" who wander from place to place bringing news and recounting folklore, accompanied by a rudimentary lute or derbouka, thus recalling the troubadours of the Middle Ages.

Having given up on evening festivities, smaller gatherings fared little better. Looking back on the reports of such gatherings, we see that most began with games of hide-and-seek and *pelote cavalière.* We had insisted to the nurses, indifferently chosen amongst European and Muslim staff, that they find activities able to awaken a kind of team spirit: in both games, players have to take into account the reactions of their companions; they cannot ignore them.

But Muslims rarely play such games. Learning to play hide-and-seek or cops-and-robbers, and acquiring a sense of team spirit takes place at school. At 10 or 12, however, Arab boys are shepherds or else they are out helping their fathers with small tasks. If we wanted these evening gatherings to work, we had to look to reality for inspiration: after work, Muslim men gather in Moorish coffeehouses. Seated around a table playing cards or dominos, or lounging on a mat discussing current events or listening to the radio, they pass the time over a cup of tea or coffee. And this is exactly what the experiment showed: after a few weeks, when the nurses had lost all initiative, those patients who conceded to staying awake would just listen to the radio.

Other than these attempts at active resocialization, the recreational activities organized by the hospital were not as "vital" a need for the Muslim as for the European. Thus for the most part, the films shown did not seem to provoke any kind of emotional engagement. Some of the latest films screened were: *Little Women, King Solomon's Mines, Les noces de sable, La duchesse de Langeais, Crisis, Rio Grande, Thérésa Raquin,* etc. Of course, only the action films without deep psychological or sentimental plots were even remotely followed. Yet rather than invoking a kind of "primitivism," we can probably attribute disinterest to the impossibility for the Muslim of comprehending the reactions of Western characters completely foreign to him. The example of Cocteau's *Les noces de sable* is particularly telling. It relates the adventures of an Arab prince who goes to find his fiancée amongst the nomads of the Sahara. Although the costumes and decor are reminiscent of North Africa, the psychological plot is Western. It did not interest the Muslim patients because they could not fully participate in the action or identify with the characters. The same was true for most of the other films. In the "action films," however, plots are simple, images speak for themselves, and language is all but unnecessary.

This held for the special events organized at the European pavilions also: if a popular song was sung or plays such as *Les précieuses ridicules, Le médecin malgré*

lui, Cyrano de Bergerac or a play by Courteline or Colette were performed, a whole section of the room remained completely indifferent. At best some were shaken out of their stupor by an actor throwing a glass of water at another's face or beating him with a stick.

Our failure with the newspaper was even greater: as it primarily relates the social life of the hospital more or less accurately, it is of little interest to those who remain excluded from the goings on. This is why even patients who could read and write never contributed articles. However, we failed in large part because most of our Muslim patients are illiterate. Of the 220 patients on our ward, five can read and write Arabic, two can read and write French. All the others never learnt the alphabet. And of the 16 who were considered "literate," only 6 were educated past primary school.

We initially thought to remedy this problem by having nurses write the articles for patients who were unable or unwilling to write themselves, as we did for the Europeans. However, uniformly utilizing this procedure was practically useless. In reality, given the illiteracy prevalent in Algeria, culture takes more oral than written forms and teaching takes place through speech. Amongst every group, there are generally one or several literate persons charged with reading and writing for the rest. That is why we so often recognize the handwriting of the same "*Taleb*" or public scribe in the letters we receive from parents of patients who live in the same *douar*. And we spoke earlier of the importance of the "storyteller" who wanders from village to village, bearing news and folklore in the form of epic poems that relate events of centuries past, thus maintaining the cultural ties between different regions.

To conclude this rendition of our initial failures, a word on ergotherapy. In highly industrialized Western nations, it is easy to set up rehabilitation strategies from already existing frameworks; for the Algerian Muslim who lives in a context that remains feudal in many respects, rehabilitation is much more difficult. Men work the land without specialization. They sometimes practice a rudimentary artisanal trade outside of urban centers but are loath to work with wool or raffia because this is considered women's work: women are the ones who weave baskets and mats.

Although one could organize raffia, pottery, and weaving workshops in the hospital, it seems a better idea to leave this kind of work to female patients. For the men, it is best to start from the most general dispositions and the most firmly anchored in the personality of the patient; we tested this with delusional and catatonic patients. We simply had to place a pick or a shovel in their hands for them to start picking and hoeing without being pushed to work. These peasants are close to the land; they are bound to it. And if we can manage to interest them in a particular plot of land and its cultivation, then the work will truly become a factor in restoring mental equilibrium. This kind of ergotherapy could then be integrated as a specific social activity.

* * *

We now know why our first attempts at implementing sociotherapy among Muslim patients failed. We also believe that this failure was not in vain insofar as we have

06_Fannon_cha04.indd 84 10/7/2014 5:37:45 PM

understood the cause. Since then, we have shifted the focus of our efforts and seen tangible results.

There is now a Moorish coffeehouse within the hospital, regular celebration of traditional Muslim holidays and periodic visits by professional "storytellers." And the number of new patients that take part in activities increases with each new event. Although we are only in the early stages of developing this new social life, we believe that our methodological errors are behind us.

Notes

* In collaboration with J. Azoulay first published in *L'Information psychiatrique*, vol. 30, no. 9, 1954.

1. At Saint-Alban, the group psychotherapy sessions were mainly held in the context of club meetings or meetings of the newspaper commission. But since we were still at the experimental stage [at Blida], we were forced to group everything at the pavilion level.
2. The committee will only start selecting films next year as this year's programming has already been set.
3. TR: A game played by school age children.
4. Sans Nom Patronyme [without family name].
5. The film screenings take place in the chapel.
6. Regarding "working patients," the same critique can be made of most psychiatric hospitals: patients leave early and don't return until the late morning or evening. They more or less miss out on all therapeutic activities.
7. Patients break their spoons to use the handles as passes to open doors. The number of broken spoons during the course of a month is impressive.
8. J. Paumelle: "Le mythe de l'agitation des malades mentaux" [The Myth of Agitation amongst Mental Patients] in *Entretiens Psychiatriques* vol. 2, 1953, pp.181–193 l'Arche Editeur.
9. As Georges Gusdorf rightly demonstrated in his *Traité de l'existence morale* [A Treatise on Moral Existence] (1949).
10. Called you yous (ululations).
11. TR: They are referring to Azoulay's unpublished thesis: *Contributions à l'étude de la socialthérapie dans un service d'aliénés musulmans* [Contributions to the study of sociotherapy on a ward of Muslim psychiatric patients].
12. North African village.
13. *Khammes: métayers* who work the land for one fifth of the revenue obtained.

06_Fannon_cha04.indd 85 10/7/2014 5:37:45 PM

06_Fannon_cha04.indd 86 10/7/2014 5:37:45 PM

Chapter 5

The Conduct of Confession in North Africa*

In order to answer the fundamental question asked of him—namely, whether or not "the accused was in a demented state while committing a criminal act"—the physician in charge of a psychiatric evaluation must discover or at least seek out, with the help of the accused, the ideas, values, and mental state that informed the decision to act and its execution. In medico-legal practice, the experience of the act, its justification, the psychic conflict at its source—in other words, the events from the point of view of the accused—are always of the utmost importance. The psychiatric expert must therefore try to discern the truth of the act which is also the foundation of the truth of its author.

The accused may experience the denial or rejection of his act as a fundamental alienation of self. Whereas to claim it and take full responsibility (as Sartre's hero, Hugo, does when he asserts that he has nothing left but his own act) is to escape the absurd and give meaning to his life. Once the internal coherence of the criminal act has been established and the accused has accepted the blame, prompting self-condemnation, and a veritable segregation ensues, according to the rapporteur, confession becomes the ransom for his rehabilitation and return to the social group. Only, is it not obvious that such a favorable resolution is impossible without a preexisting reciprocal recognition of the group by the individual and vice versa?

We would like to provide a few brief observations that may be of interest on this point from our experience of medicolegal practice in Algeria. The particular complexity of confession is made abundantly clear by the psychiatric evaluations practiced on Algerian Muslims. Though the rapporteur claims the accused generally confesses before a psychiatric evaluation is carried out, in Algeria, psychiatrists often find themselves before perpetrators that completely deny their alleged crimes to the point of having no explanation for their present detention.

In the case of crimes committed by Kabyles that are covered by Berber customary law, with traditional rules that remain as inflexible and rigid as ever (e.g., on murders or attempted murders connected with inheritance, the sale or exchange of land, or even marital infidelity, etc.), up to 80 percent end in denials. This despite the fact

07_Fanon_cha05.indd 87 10/7/2014 5:38:45 PM

that preliminary investigations are often quite telling. At times denial is established from the very beginning, but more often a complete confession is obtained by the preliminary investigators, including motive, a narrative of events, and the reconstitution of the scene of the crime. This tends to carry through the trial and the first months of detention until one day the accused retracts his confession, denying everything *en bloc* and, in many cases, claiming that confession was made under duress. Once the retraction becomes definitive and unshakeable, the accused no longer tries to actively prove his innocence but simply claims it. He says his fate is in the hands of the Law: he will be punished if the verdict demands it. He accepts it all in the name of Allah (we will return to this genuine sense of submission later).

We can easily imagine how uneasy the psychiatric evaluator might be under these conditions. He is genuinely unable to answer that first fundamental question, being deprived of the diagnostic value of the confession the rapporteur claims took place, having explained the great difficulties that ensued from the retraction. The act is no longer appropriated by the accused and therefore stands without an author, rendering any kind of criminological understanding impossible to obtain.

Only the file remains. And the charges it contains, as we have seen, often weigh very heavily against the accused. He reconstituted the crime, revealed the location of the weapon and several witnesses confirm having seen him strike (though sometimes even the witnesses retract their testimony). Therefore, when the time comes for the psychiatric evaluation, the expert finds himself in the presence of a lucid, coherent man proclaiming his innocence. There is no appropriation of the act and by extension, no subjective consent to sanction, acceptance of condemnation or even culpability. The psychiatric expert is unable to uncover the truth of the criminal.

We might be able to approach this ontological system that escapes us by inquiring whether the indigenous Muslim really thinks of himself as engaged in a contractual agreement with the social group that now exerts power over him. Does he feel bound by a social contract? Does he feel excluded because of his crime? And if so, from which group? The European? The Muslim? What significance would the crime, trial, and sentence have if he were not?

Of course, we can ask a different question in order to avoid answering this one. We can also just say that the North African is a liar. This notion is widely admitted. Any magistrate, police officer, or employer could come up with a number of convincing examples (the North African, it turns out, is also lazy, underhanded, etc.). But can such simplifications help us discover the truth which remains so far out of reach? The orchestration of falsehood briefly described above requires a more complex explanation.

In any case, a liar is himself a being constantly grappling with the problem of truth. Thus, to affirm that a race suffers a propensity for lying and voluntarily dissimulating the truth, or that it is incapable of discerning true from false and integrating the results of experience because of a supposed phylogenetic deficiency, is merely to dispense with the problem without resolving it. The way to a solution could involve the notions mentioned earlier: primarily, that the rehabilitation of a criminal by confession depends upon the recognition of the group by the individual.

In effect, rehabilitation cannot take place if there is no belonging to begin with. According to the rapporteur, whenever several social or ethico-social entities coexist,

07_Fannon_cha05.indd 88 10/7/2014 5:38:45 PM

there is no homogeneity or harmony within the group. The subjective consent of the criminal that grounds and valorizes the sanction cannot be obtained under such conditions. Fundamental adherence to the process presupposes a coherent set of collective attitudes or ethical universe.

For the criminal, recognizing his actions before a judge means disapproving of it and legitimizing the encroachment of the public on the private. Is the North African not refusing all of this by his denial and retraction? Undoubtedly, this is a concrete instance of the total separation between two coexisting social groups where, alas, integration has not yet begun.

The refusal of the Muslim accused to authenticate the social contract by confessing his crime means that his often profound submission in the face of power (judicial in this case) noted above is not to be confused with acceptance of that power. These scattered remarks merit much deeper development. Nevertheless, they do show the immensity and seriousness of the problem thwarting the psychiatric expert's task in Algeria, which is why we chose to present them here.

Note

* In collaboration with R. Lacaton. Presented at the *Congrès de Psychiatrie et Neurologie de langue française*, LIII, Nice, 1955; and later published in *L'Information psychiatrique*, vol. 51, no. 10, décembre 1975.

07_Fannon_cha05.indd 90 10/7/2014 5:38:46 PM

Chapter 6

Ethnopsychiatric Considerations*

Ethnopsychiatry has been much discussed over the past few years. Important monographs have been written and reports presented. The World Health Organization has just officially sanctioned these works with the J. C. Carothers report. The present acquisitions in the field seem sufficiently solid to validate an attempt at systematization.

Professor Porot of Algiers was the first to attempt to outline a psychiatric approach to the Muslim in 1918.[1] In his notes on Muslim psychiatry, he noted the main characteristics of the indigenous North African in a vigorous diagram:

- Absence, or near absence of emotional sensitivity,
- Gullible and suggestible to the extreme,
- Tenaciously stubborn,
- Mentally puerile, minus the curiosity of a Western child,
- Prone to accidents and pithiatic reactions.[2]

In his work with Arii published in 1932 on the criminal impulse of the indigenous North African, Porot did not make any serious modifications to his approach. He simply recalled that the Kabyle was "intelligent, educated, hardworking, thrifty and therefore escaped mental retardation, fundamental defect of the Algerian."[3]

It is especially in 1935, at the *Congrès des Médecins Aliénistes et Neurologistes de langue française* held in Brussels that this fecund idea was introduced. Discussing Baruk's report on hysteria and considering the specific case of the North African, Professor Porot explained that the native, big mental retard that he is, with limited higher cortical faculties, is essentially a primitive being whose life is mainly vegetative and instinctual since it is regulated by the diencephalon. And the slightest psychical shock mostly results in diencephalic responses, much more so than psychomotor and differentiated reactions.[4]

In April 1939, in *Sud Médical et Chirurgical*,[5] Professor Porot would return to the question with Doctor Sutter. While examining the problem of epilepsy,[6] the authors

concluded: "Primitivism is not a lack of maturity, an abrupt end to the development of an individual psyche; it is a social condition that has arrived at the end of its evolution and has logically adapted to a life different from ours. It is not only a way of being resulting from a specific type of education; it has a far deeper base and we even suspect that its substratum must be uniquely situated in the architecture or at the very least in the dynamic hierarchy of the nerve centers."

Thus for the Algiers School, the subcortical region, or more specifically, the diencephalon is dominant in the North African. When they are cortically integrated, psychomotor functions are very fragile, labile, and in fact, dependent on the diencephalon.

This is when a number of works overseen by Gallais were to add a scientific base to these hypotheses. Studying the recordings of electroencephalograms run on Blacks, the authors deduce the existence of neuronal immaturity with a tendency toward paroxystic manifestations on the one hand, thus proving the predominance of base nerve centers on the other hand. The hypothesis of the Algiers school was thus verified on a psycho-physiological level; the Black African greatly resembles the North African; there is uniformity of the African.

In 1954, Doctor J. C. Carothers[7] was asked to direct an ethnopsychiatric study of the Black African by the World Health Organization. His report, despite the fact that its scope is limited to British Africa, conforms to the conclusions of the French authors:

Lobotomy, which neurosurgery has accustomed us to, allowed the author to better understand the African for, as he says, "The resemblance between a leucotomized European and a primitive African is very often complete." "The African, with his total lack of aptitude for synthesis, must consequently make very little use of his frontal lobes and all the singularities of African psychiatry can be related back to this frontal apathy."[8]

"This is the data for cases that do not concern the categories of the European. They were collected in different regions of Africa—East, West, South—and, on the whole, each of the authors had little or no awareness of the work of the others. The essential similarity between these works is therefore quite remarkable."[10]

Notes

* First published in *Conscience maghrébine* 3, 1955.

1. *Annales Medico-psychiatriques*, 1918.
2. Meaning hysterical.
3. *Annales Medico-psychiatriques*, 1932—no. 5—p. 588 onward.
4. Ibid. p. 264.
5. Le Primitivisme des indigènes nord-africains (ses incidences en pathologie mentale) [The Primitivism of North African Natives (instances in mental pathology)].
6. *Algérie Médicale*—March 1938—p. 135 and onward.
7. Psychologie Normale et Pathologie de l'Africain [Normal Psychology and Pathology in the African] in *Etudes Ethnopsychiatriques*. Masson&Cie Editeurs.
8. Ibid. p. 176.
9. Ibid. p. 178.

08_Fannon_cha06.indd 92 10/7/2014 5:40:28 PM

Chapter 7

The TAT and Muslim Women: A Sociology of Perception and Imagination*

The Thematic Apperception Test (TAT) is a projective test that consists in submitting to the subject a series of situations and perceptual panoramas within which lines of force emerge spontaneously that prompt a restructuring of the field by the Ego. The polymorphism of formal content, the progressive complexity of situations, and the rich and diverse possible identifications allow for the appearance of ambiguous meanings at the level of interpretation. Published work on the TAT is quite rare, contrary to the bibliographical abundance on the Rorschach test. At the International Congress of Psychiatry in 1950, Guerra paid particular attention to it in an exhaustive doctrinal study of methods of projection. Although Guerra's use of factor analysis is always contestable, it is the first time that phenomenological, *gestaltist,* anthropological data are presented: thus, for example, the encounter of man and his world is mentioned. In any case, one of Guerra's positions is worth noting here: "As a projective test, the TAT presents characteristics related to origin that reflect a specific epoch and social structure."[1] Within the context of Western civilizations that share similar levels of technology yet sometimes differ in terms of cultural characteristics, we are asked to take into consideration specific rhythms of life, customs, and social facts.

In a talk given at the Royal Belgian Ethnographic Society recently, Ombrédane returned to this question. Legitimating Guerra's doctrinal position, Ombrédane formulated a variation of the TAT intended for Blacks in the Belgian Congo.[2] For our part, we would like to share the results of a fairly original experiment we conducted in North Africa. We submitted a standard TAT to a fairly large group of Muslim women in the open ward of the Blida Psychiatric Hospital. We have a dozen or so observations worth noting. The test was submitted to mild hypochondriacs with slight anxiety, emotionally disturbed women still living with their families and without severe behavioral problems, and to a case of juvenile mania that was subsequently cured with no sign of relapse.[3] What general responses emerged? How

09_Fannon_cha07.indd 93 10/7/2014 5:42:34 PM

do Muslim women react to the TAT? How do they experience the test? What do they understand of it?

Amongst European women, the perception [part of the test] was totally and immediately satisfied. They identified with the images straight away. The Muslim women, however, adopted a radically different approach. We saw them take on a patient, laborious, tenacious effort of decipherment and analysis.

For example:

Card *3 BM* (obs. 4.)

> "I don't know if it's a boy or a girl. I think it's a girl. I don't know what she's doing. I don't know what to say. I don't understand. Maybe he's sick. He has a headache. [Sigh] I'm tired."

Card 11 (obs. 7.)

[Laughter]

> "It looks like the sea, but the sea is blue or green and here it's black. It's not the sea; maybe it's a village [repeatedly turning the card.] It looks like an airplane, a boat, but it can't be that. I don't understand. It looks like a snake? It looks like a person [the card depicts stones]. [The card is being held in the right direction.] It looks like a group of people but you can't really see them well. [stones]."

This unusual approach turned the test into a gage of intellectual performance. We had the impression that patients were striving to find the greatest number of known things in the cards. Paradoxically, however, the responses were disorganized, empty, and disconnected. Most of the time we only managed to obtain basic enumerations. No overarching theme came to light; no structure emerged. Narrative was non-existent. There was no staging, no drama. We were presented with disparate elements gleaned at random from the cards. What Dana calls perceptual organization was nowhere to be found. Despite our precise instructions, the Muslim women would not tell us what happened but focused instead on what was there.

We should also mention several misidentifications: for example, the violin on card 1 was described as a "coffin" or a "cradle;" the crosses of a cemetery (card 15) as couch grass brushes or doghouses. Figures that were plain as day, like the sun on card 17 *GF*, or the gun on card 8 *BM*, were not picked up.

In terms of the test-taking process, where situations that might appear conflictual or ambiguous behavior from those involved would generally engage the Ego, responses remained empty, bland, and insignificant. The analysis of perceptual modalities shows that the test was not understood; it was transformed into an aptitude test for decoding or reading. This intellectual, rational, pointillist response is paradoxically understandable, even though it clashes with Murray's intentions. It results from the situation in which the patients were placed.

By asking them to experience and describe a scene constructed by Westerners for Westerners, we plunged them into a different, strange, heterogeneous world impossible to appropriate. Their initial reactions were, in fact, of astonishment and perplexity before the unknown: "My God, what is that!" The Muslim women scrutinized the cards for identifiable elements, but the lines of force organizing that

09_Fannon_cha07.indd 94 10/7/2014 5:42:35 PM

perception were absent: they "sounded out" the cards without experiencing them. This explains why despite an intellectual effort as important, as laborious as theirs, we were only able to obtain disorganized responses that did not pass beyond the stage of enumeration, of "what was there." This also explains perceptual errors and elements gone unnoticed.

The absence of correlation between the "perceptual stimuli" we offered our subjects for investigation and the anticipation of a precise, exacting, and in a sense spasmodic cultural context, accounts for these errors. The incoherent, ill adapted, unclear, dislocated responses and perceptions that resembled caricatures signaled to us that our method was wrong. We should have begun by thematizing the dynamics circulating throughout Maghrebi society, the lived experience of European presence, the marginal existence of the Muslim that inevitably induces scotomization and disinterest—the cultural reality, in effect. The disadaptation of our patients was a corollary of the method's lack of adaptability.

We ran into analogous difficulties when exploring the imaginations of our patients. We rarely obtained narrative responses to the questions, "according to you, what is happening here and what will happen next?" and when we did, they were without psychoanalytic value. The short, disorganized responses were consistently banal and devoid of inventiveness. If the TAT was meant to stimulate literary creativity, it never fulfilled its promise with our patients. In some cases, patients even refused to invent stories around the cards. They opposed the whole process with statements of absolute ignorance: "I don't know what happened before... I'll only say what I know."

Others justified their refusal based on specific Quranic requirements: "I cannot lie because that's a sin. Only God knows what will happen next." From this perspective, appropriating the future amounts to substituting oneself for God—something unimaginable to a Muslim. In reality, we should be looking for what lies behind this absence of imagination and refusal of fiction. To say that Muslims are incapable of imagination, with reference to a particular genetic constitution that is part of a more general primitivism, is a difficult statement to defend. Similarly, the explanation given by the Muslim woman who felt the need to appeal to Quranic injunctions is also one that we need to look beyond. In effect, this response can be explained by the very logic of imagination.

The life of the imagination cannot be isolated from real life: the concrete, objective world constantly nourishes, permits, legitimates, and grounds the imaginary. Imaginary consciousness is certainly unreal, but it is saturated with the real. Imagination and the imaginary are only possible to the extent that the real belongs to us. Here, the card is the matrix. Yet in our analysis of the perceptual modalities of the patients tested, we noticed that the cards did not provide any schema or culturally specific patterns. There was no homogeneity between what we showed patients and what they *knew*. The world depicted was unknown, strange and odd to begin with. Faced with unusual objects and unidentifiable situations, rejected by panoramas hostile because of their heterogeneity, the Muslim women were unable to formulate an imaginary existence. The rare narratives obtained did not render a world. In an interesting development of the test, however, our patients were able to unleash their imaginations when presented with the blank card, no longer encumbered by

a foreign cultural yoke. They constructed rich and varied narratives once free from having to stumble over a world that excluded them.

Although sanctioned by systematic failure, it seemed appropriate to report this experience. We are presently developing a projective test intended for Maghrebi Muslims, based on the cultural research we conducted. The few attempts at testing carried out so far confirm our conclusion: the apparent indetermination of projective tests must be inscribed within a spatio-temporal context, animated by cultural dynamics consistent with the psycho-affective structures examined.

Notes

* In collaboration with R. Lacaton. First published in *Congrès des médecins aliénistes et neurologues de France et des pays de langue française*, Bordeaux (30 août–4 septembre 1956): 364–368.

1. Ajuriaguerra: Le TAT comme modèle des methods projectives, in "Psychiatrie Clinique," p. 56 *et. seq. Congrès International de Psychiatrie*, 1950, Hermann Editeurs.
2. A. Ombrédane: *Exploration de la mentalité des Noirs Congolais au moyen d'une épreuve projectif. Le Congo T.A.T.* [Congo T.A.T.: An Exploration of Congolese Mentality] 1954 reissued 1969, Paris: Presses Universitaires de France, 1969.
3. In terms of ethnicity, there were three Kabyles and nine Arabs. The median age was 23. A rural background predominated. None were ill.

09_Fannon_cha07.indd 96 10/7/2014 5:42:36 PM

Chapter 8

An Introduction to Sexual Disorders Amongst North Africans*

During the course of our psychiatric practice in Algeria, the abundance of disorders caused by or linked to sexuality came to our attention. The basic modalities of these disorders are limited to different types of impotence in men and vaginismus in women. The recurrence of this theme in delusions prompted us to find out to what extent it originated from normal consciousness. We therefore had to examine normal consciousness, core beliefs, and so on.

A quick survey allowed us to note that sexual impotence is all the more preoccupying as Muslim society is founded on male authority. Any deficit in virility is experienced as a major alteration in personality, as though the essential attributes of a man who has become impotent were targeted. And impotence seems to occur proportionally much more frequently amongst the Muslim population than the European one. A number of Muslim practitioners we questioned confirmed that they see two or three cases of impotence [in a single day] of consultations. Even though the doctor is generally the last to be consulted on such matters. The *marabout* or *taleb*[1] is sought out first because, as we shall see, these disorders are almost never attributed to an organic cause. They are most often related to the practice of magic and must therefore be treated as such.[2] Parallel phenomena related to female sexuality, which we will examine further on, can also be understood through this perspective.

We will attempt to outline a psycho-pathological understanding of these sexual disorders:

I—We can clinically distinguish approximately three broad types of impotents: impotence based on a hormonal deficit, impotence with a neurological source linked to organic alterations in the lumbar-sacral [bone] marrow and central nervous or psychical impotence. These distinctions are partially to be found in Muslim beliefs. We were able to talk to a *taleb,* S.A...., based in Castiglione, not far from Alger, with a good reputation in the region; you might even say specialized in the

treatment of impotence. His explanations left us rather confused in fact, but he based his remedies on a book that we were able to find, in which impotence was minutely analyzed from a clinical, etiological, and especially therapeutic standpoint. The book is called *Livre de la Clemence sur la Médecine et la Sagesse* by El Soyouti, a medieval Arab writer, better known as a commentator of the Quran.[3]

For El Soyouti, impotence can have three different causes: the malformation of sexual organs, the breath of demons, and magic:

a) The first type includes any impotence due to visible genital malformations: insufficient development, testicular atrophy, etc.... This kind generally comes with weakness and lack of sexual desire. Impotence is attributed to infirmity here and is usually beyond the therapeutic means of the *taleb*. It is mainly in these cases that patients are more easily or even systematically referred to a doctor. At most, says Soyouti, we can try to have the patient ingest the member of a wild ass, taken from the animal before it dies, and mixed with certain spices listed in great detail.

b) Impotence caused by *djinns*[4] has a different character: "a man made impotent by the breath of demons can be recognized by the fact that he ejaculates before having relations with a woman," says Soyouti. As we can see, he is referring to premature ejaculation.

This kind of impotence is interpreted as a punishment exacted by *djinns* that the man in question must have irritated in a more or less distant past. And we know that *djinns* are particularly sensitive, hence the constant need for propitiatory rites to guard against their wrath: "We recommend that you bring your hand to your mouth and pronounce a "bismillah" before spitting for fear of the earth spirits, so that if there happens to be one near by, it will be warned to move away... Urinating also has its corresponding rites of warning, guidance, behavior, etc... to which the country folk stay faithful. Care is taken to prevent children from urinating, especially at night, in the streets, internal courtyards and gardens, on garbage, or any spot thought to be haunted. Those who disrespect the genies, who, according to the Arab expression, "undermine their status or prestige,"[5] are almost invariably punished by pathological afflictions such as skin conditions, taking away the use of one of the senses, nervous conditions, or madness.[6] As an example we can cite the case of one of our patients who attributed his impotence to the time when he accidentally stepped in the blood of a sheep just slain for the *Mouloud [Mawlid]* festivities.[7]

The man made impotent because he has offended the *djinns* must consult a *taleb* who will seek to appease them through various means: invocations, creating amulets that must be permanently worn close to the body in which various magic formulas are inscribed and stored in leather pouches, or ingesting specific concoctions. And the *marabout* we consulted claims the results are usually good.

c) The cases of impotence attributed to the practice of magic or bewitchment, seem to be the most common and the most complex. This kind of impotence takes the form of not being able to have or sustain an erection past the moment of penetration. The man in this case is said to be bewitched or "bound," the *marabout* tells us.

These spells are generally cast by a wife who wishes to render her husband impotent, or she will have recourse to another woman known for her adeptness in the practice of magic if she does not feel sufficiently knowledgeable herself. This kind

10_Fannon_cha08.indd 98 10/7/2014 5:40:45 PM

of impotence is most often selective: a wife will bind her cheating husband so that he becomes impotent for any other woman but herself. These spells are more or less lawful; they are accepted within the collective morals. They belong to what is known as white magic.

But the binding can also be generalized, rendering the man completely impotent. This might be implemented, for example, by a jealous or abandoned wife who wants to take revenge on her husband. It is considered a malevolent action taken under the influence of the "*Shaitan*" and clearly condemned by society as belonging to black magic; for if the former is about protecting a union and promoting values, the latter is only about destruction and annihilation.

There are many different procedures for this. We will describe some of the most common. A wife who wishes to bind her husband must measure the size of his erect member with a piece of string made of wool. She then ties a knot on each end of the string and hides it. The man becomes impotent. Or she can place a brand new circular mirror at her husband's feet, forcing him to step over it unwittingly. Other times it is an unsheathed knife that the wife places under her husband's step and later sheaths back up again.[8] Some methods are even more picturesque. Near Algiers, a wife wishing to bind her husband is advised to collect a few drops of his sperm and knead it into white clay found in a specific area in order to make a small statuette with a human form. It is then hidden in a place only the wife knows, generally an abandoned tomb in a nearby cemetery. Finally, the spell can be written out on a goat's horn to be tossed into a cemetery: this makes the man become progressively impotent.

This list is nonexhaustive. Methods vary according to place and local customs but they do have certain characteristics in common. First of all, essential value is placed in the word; in casting spells, there is always an invocation, an incantation to accompany the act. That is why it is necessary to know the lineage of the man being bound, especially his mother's name. In magic rites, the act of binding comes with statutes of limitations, orders, and outright verbal indictments.

We should note the importance of knots and ties in these binding practices which are, in fact, present in all magical-religious phenomena: "knots and strings are also of importance in the nuptial ritual to protect the newlyweds whereas we know that knots are precisely what may impede the consummation of a marriage. But we can see this kind of ambivalence in all magical-religious usages of knots and ties... In effect, it is the orientation given to the energy that resides within any bond, within any act of binding that is essential to all of these magical or magico-medical rites."[9]

The man thus rendered impotent can be cured if the woman abandons the spell by destroying the knot or substitute-statuette. But the wife is not always so forgiving, hence the necessary intervention of the *taleb* here too. Just like in the preceding case, he calls upon magical formulas, amulets and different concoctions to be taken by the patient. But the formulas and concoctions in this case of impotence differ from those used against the spells of *djinns*. To be more precise, formulas and concoctions are adapted to each specific case and very complex systems that act as veritable keys are deployed to determine the nature of the impotence to be treated. These systems rely on the patient's name—with a specific number attributed to each

10_Fannon_cha08.indd 99 10/7/2014 5:40:45 PM

letter by convention—his mother's name, the date of treatment, the duration of the illness, etc.

Hence there is a fairly complex classification system, which, although very detailed, remains quite confusing in El Soyouti's work. This probably allows each *taleb* to add his personal touch. Here are a few formulas from El Soyouti we found of interest: a man made impotent by magic can be cured by ingesting various Indian herbs (ginger, pepper, and clove) if the impotence has lasted no longer than one year. If it is older than that, the patient must eat the penis of a fox or wild ass seasoned with the spices mentioned above for a period of seven days.

The impotence can also be cured by writing certain formulas and signs on an axe[10] which is then heated and cooled in [a basin of] water placed before the patient.[11] Quranic verses can also be inscribed on a saucer with the names of both wife and husband, to which is added: "Oh my God, I ask you to unite this man and this woman." Or the following Quranic formula is written beneath the patient's navel: "They who have forsaken God and the Prophet will be annihilated as were their predecessors."

Yet another means of curing impotence: a succession of cabalistic formulas is written out on a vase filled with oil, which man and woman lather over their sexual parts. Other times a cabalistic grid is drawn on a hardboiled egg with nine squares in which specific letters and numbers are inscribed, with the following characteristics written on either side of it: violent, strong, hard, powerful. The egg is fed to the impotent man and the shell is placed in a small canvas bag used to cook the egg and then hung around the woman's neck.

As we can see, the *taleb* tackles the magical spell with a kind of counter-magic: on the one hand, he attempts to replace the sex with an animal's member that serves as a kind of substitute. On the other, he responds to the magic formulas of the spell with incantatory formulas in which certain words appear such as: key, open, picket, Moses stick, etc...And the *marabout* of Castiglione cited the case of a man from Tiaret who had been bound for ten years and whom he was able to unbind in seven days using the above methods.

II—We have just seen how male impotence is most often attributed to the casting of spells, to binding. But binding can also be used on women:

a) It happens quite frequently that young girls are bound by their parents. In this case, it is to protect their virginity. We know that the young girl's virginity, in a strictly anatomical sense, must be absolutely preserved before marriage. To give away a girl as a virgin when she is not would amount to a grave insult and swindling of the husband on the part of the parents.[12] Therefore on the wedding day, the spouse's parents impatiently await the moment when the husband comes out of the nuptial chamber to present before the entire family the sheet spotted with blood, peremptory proof of his young wife's virginity. If her virginity cannot be proven in this way, the husband has the right to send her back to her parents. The young woman is then destined to a life of shame and celibacy while marriage is the only human and social recognition for a woman.

10_Fannon_cha08.indd 100 10/7/2014 5:40:46 PM

In principle, a young woman is not allowed out of the house unless accompanied by her mother or another older female family member. But sometimes, especially in the countryside, this rule cannot be upheld because the goats and sheep need tending, the fields need gleaning, or water needs to be fetched at the spring. That is why parents take the precaution to bind their daughters, to avoid any "accidents." It is protection for the whole family and the binding therefore has no occult aspect to it. It is performed with the person's full knowledge and she plays a role in the rite.

Here too there are many different techniques that vary depending on local and family tradition. One that seemed to be employed particularly frequently was explained to us by a Muslim nurse on our ward who had been bound by her parents before her wedding: the young girl is placed on a brand new trunk with a lock.[13] The girl's mother locks the trunk while pronouncing a consecrated formula and the girl is bound. When the time of the wedding comes, these motions are repeated in reverse: the young girl is placed on the trunk, her mother opens the trunk and the binding is lifted.

These rites also often include the use of ties, knots, and padlocks whose symbolic value is evident, the result being always the same: the girl is protected against any attempt to take her virginity, be it consensual or not. The way the protection works is not always made clear: in general, it seems to render impotent any potential deflowerer.

And the protection is so absolute that it sometimes has unforeseen consequences. We were told of a woman who had been bound in her youth and whose mother died before having unbound her. Despite having been married several times, each husband sent her back to her family, not being able to have relations with her. And another anecdote had it that the uncle of a young woman went to see her mother to complain that she was seeking out the company of boys rather too avidly and he feared for her reputation. The mother retorted that there was nothing to worry about since she was bound.

b) Young girls are not the only ones to be bound. The parents of a woman repudiated by her husband can resort to binding in order to be sure that she upholds her transitional celibacy. And it is said that sometimes parents wait until a few days after the new wedding before unbinding their daughter to prove to the husband that she had remained serious since her divorce.
c) Sometimes a husband is brought to bind his wife, especially when he has reasons to doubt her fidelity. This kind of binding can take two forms: in general, it renders impotent any man other than the husband who wishes to have relations with his wife. The same notion of selective binding described earlier for impotence-binding applies here. But it also happens that the spell affects the spouse by taking away all desire, even a taste for life, which leads to a veritable affective death that does indeed eliminate any risk of conjugal infidelity.
d) Finally, a woman can be bound by another woman, even by a stranger: this kind of binding is often practiced by a woman cheated upon or abandoned for another woman, and who binds the latter to prevent her from staying

10_Fannon_cha08.indd 101 10/7/2014 5:40:46 PM

with her husband. But, if in the previous cases the binding of a young girl or woman was considered normal, lawful, and accepted within the frame of collective morals, here it takes on the aspect of vengeance, malevolence and is condemned as such by society. We find the same distinction between black magic and white magic observed in the cases of male binding.

Notes

* Unpublished draft paper written in collaboration with J. Azoulay and F. Sanchez.

1. *Taleb:* he who writes. A kind of medicine man whose primary attribute is to know how to read and write the old Quranic formulas. They are all the more important as the majority of the population is illiterate.
2. See Desparment. *Le Mal Magique*. Alger: Jules Carbonel, 1932.
3. *Livre de la Clemence sur la Medecine et la Sagesse* [*Book of Clemency on Medicine and Wisdom*] by Jalal Eddin El Soyouti, edited in Tanta—Cairo, by Mustapha Tadj El Koutoubi. The passages cited are our own translations.
4. *Djinns* or demons play an important role in the mental pathologies of North Africans. The influence of *djinns* in psychiatry is thoroughly analyzed in S. Taieb's thesis, inspired by Professor Porot. One of the authors is also currently working on a piece that addresses the links between belief in genies and the different levels of destructuration of consciousness.
5. TR: Translated into French from the Arabic by the authors as "ébrèchent leur prestige."
6. Desparment. *Le mal magique*.p. 194 (op. cit.).
7. The blood and milk spilt on the ground must not be sullied: they are meant for the earth spirits. Some fanciful commentators of the Quran think the fact that consuming blood is prohibited should be interpreted in light of this. (Surat Al-Ma'idah [The Table Spread], verse 4).
8. TR: The sentence in French is ambiguous. It literally says the knife is opened and then closed. The authors might have meant scissors instead of knife, or maybe a pocket knife? Or lastly, the option chosen in the text.
9. Mircea Eliade. "Le Dieu Lieur" [The Binding God] in *Images & Symboles*. Gallimard: 1952, p. 147.
10. The axe cuts the binding.
11. He breaths in the steam given off.
12. To be sure, the dowry for a virgin is far greater than the dowry requested for a woman already deflowered.
13. Some say it is best to buy the trunk in a store that faces Mecca.

10_Fannon_cha08.indd 102 10/7/2014 5:40:47 PM

Chapter 9

The Maghrebi Muslim Attitude toward Madness*

In textbooks devoted to the history of psychiatry, the creation of institutions for the mentally ill in Muslim countries is always said to have occurred as early as the Middle Ages, at a time when these kinds of establishments were still quite rare. The Muslim attitude toward madness is therefore of considerable importance to us. We will limit our study here to the position of the Maghrebi Muslim toward mental illness, informed by our experience in North Africa and more specifically, in Algeria.

It is commonplace to hear talk of the Muslim crowd's respect and veneration of the mentally ill, said to be in intimate contact with the mysterious world of the *djinn*, the occult thus eliciting respect and veneration. Such assertions do not seem to us entirely accurate in the Maghreb. We will try to interpret the facts by shedding light on them from the inside, starting by paying attention to how the Maghrebi view the world. How does the Maghrebi behave toward those around him deemed mentally ill? Before answering this question, we would like to try to define a working-class Westerner's behavior in similar circumstances.

Westerners generally believe that madness alienates man, that it is impossible to understand the behavior of the mentally ill without taking into account the illness. However in practice, this belief does not always lead to logically contiguous behavior. Everything takes place as though the illness is forgotten about. To the Westerner, the mentally ill appear to wallow in their pathology, tending to use it in order to take advantage of those around them. The ill are held responsible for their words and actions to the extent that these are imagined as products of an active will. Thus if a patient is aggressive, one shouldn't believe the aggressiveness to be entirely a function of the pathology: it is partially ambiguous, partially the result of a conscious intent to harm. When blows are struck, responses follow that do not merely aim to restrain but also to punish. Some patients spend days on end in a state of immobility, frozen in a corner, only moving to take their meals and return to bed. One is tempted to think they have chosen to live thus, as social parasites willing to starve to death if abandoned to their lot. The collectivity comes to think

11_Fannon_cha09.indd 103 10/7/2014 5:39:39 PM

this dependency as a moral constraint imposed on it by the ill. Medical personnel in psychiatric hospitals often hold similar views. This or that nurse will feel hurt by a megalomaniac's disdain and keep a grudge toward the patient that might manifest itself by the denial of a snack or walk outside.[1] Or a mother, whose son snubs her when she visits, leaves the hospital full of resentment. Of course, she knows her son is ill, but she does not recognize what "right" he has to behave in this way toward her, with no care for her old age, affection, and solicitude.

However, if there is any established certainty, it is the Maghrebi view on the subject of madness and its determinism: the mentally ill are absolutely alienated. They are not responsible for their affliction. The *djinns* bear sole responsibility while the patient is simply the innocent victim of the *djinn* or *djinns* that possess him. It is not their fault if they are rude, menacing, or persist in a total lack of realism. A mother insulted or even beaten by her mentally ill son would never dream of accusing him of disrespect or murderous desires: she knows that her son would never wish her harm were he free. There is never any question of attributing to him acts that are not a function of his free will since his is entirely subjected to the influence of the *djinn*. The collectivity never adopts an aggressive or suspicious attitude toward the mentally ill and, in principle, neither are they excluded from the group. However, the family may have recourse to restraining the patient. Is it not advisable in certain cases to momentarily subdue the *djinns* when they seem intent on threatening the security of the patient or group? *Djinns* are the agents of such excesses. The group agrees not to attribute any intent to harm to the patient, recognizing the evil, duplicitous role played by the pathogenic *djinns* who possess him. The patient's behavior is thus "interpreted" according to these general beliefs. His reputation remains intact and he is given the same esteem and social consideration as before. The *djinn*-illness is an accidental affliction. No matter how long it lasts, it remains contingent to the patient himself: only affecting appearance, but not the underlying Ego. Thus there is always hope for a cure, the search for which remains a prime concern of the group. In everyone's opinion, pilgrimages to shrines are therapeutic and repeated as necessary until a cure is obtained. If a cure is not forthcoming, the therapies that have proven most effective are to be pursued, provided one does not grow weary prematurely. When some amelioration occurs, it is taken as an indication that the course of action is useful and should be continued, having already exorcised one or more *djinns*. Once a cure is obtained the ill are able to resume their role in society without fear of arousing suspicion or ambivalence from the group. They are able to speak of past illness without the slightest hint of reticence. Is it in any way necessary to hide a state that was not directly one's doing? Ask Maghrebis about their family history of illness and they will speak of the known cases of madness without embarrassment: *djinns* are not transmitted hereditarily. In fact, cases have been cited where the duty of the husband to take his wife on periodic visits to a specific marabout was written into the marriage contract; it is important to scrupulously keep promises made to the saint that allowed a newlywed to be cured.

In effect, these observations point to a harmonious articulation of beliefs in the Maghreb instrumental to the existence and provision of "psychiatric care." This kind of care is certainly rudimentary and can only provide a piecemeal solution to madness by bringing into play the goodwill of individuals and families affected by this or that

11_Fannon_cha09.indd 104 10/7/2014 5:39:40 PM

particular case. On a social level, the system cannot be said to provide satisfactory "returns" from a quantitative perspective. On a human level however, and because it is so solidly anchored in the culture, the Maghrebi therapy has immense value that cannot be measured by its sole efficacy. This natural means of care-giving is imprinted with a profoundly holistic spirit which leaves intact the image of the normal man in spite of the existence of illness. Questions of whether illness represents punishment or divine providence are of no concern to the Maghrebi, for the designs of God are always unknown[2]: their approach is guided solely by respect for the person. Those considered mentally ill are protected, fed, and cared for by their families to the extent possible. It is not madness which gives rise to respect, patience, or indulgence, it is the man suffering from madness, possessed by d*jinns*, man qua man. Does the careful attention paid to a tubercular patient imply the existence of a particular sentiment toward tuberculosis itself? The mad deserve respect because they are still human despite everything; the mad deserve care because they are in the grip of powerful enemies. It is never a question of respecting madness as such, let alone venerating it.

However, there are certain things that should not be passed over in silence. Although it happens quite rarely, one does find mentally ill persons who have become the object of respect and veneration from the collectivity or certain individuals within the group, in certain douars of certain regions. These people are not considered mad, *mahboul*, or possessed by *djinns*, *majnoun*. They are considered saints and one believes in their *baraka*, in their beneficent power. It is understood that their spirits are drawn close to God, *majdzoub*, so close that human thought no longer inhabits their minds. Whether it is a case of mental retardation or psychosis, their fantasies, strangeness, and disorders are generally tolerable and compatible with the beliefs of the milieu.[3] We know of cases where such patients were committed to the asylum against their families' wishes who considered them saints, exempt from all illness. Certain families without resources even came to the hospital to demand the release of "their" patient—still thought to be a *marabout*—so as to gain some profit from the piety of the faithful.

Such is the Maghrebi attitude toward madness. This important point merited some explanation. It seemed of interest to describe the way North Africans deal with the issue of mental illness.

> If Europe received the first rudimentary notions of psychiatric care from Muslim countries, it brought them in return a rational understanding of mental afflictions!
>
> *Frantz Fanon and François Sanchez*

Notes

* In collaboration with F. Sanchez. First published in *Revue pratique et sociologie de la vie sociale et d'hygiène mentale* 1, 1956.

1. We remember the case of an epileptic whose mood swings were accompanied by rude remarks toward the staff which "drove" them to lodge a complaint with the *médecin-chef*.

11_Fannon_cha09.indd 105 10/7/2014 5:39:40 PM

They went so far as to suggest that the patient be reprimanded for abusing their generosity. We also have in mind certain articles that speak of "bloodthirsty madness," of murderous 'madmen,' veritable "filthy beasts" who often take advantage of the "credulity" of psychiatric examiners.

2. Mektoub. (TR: That which is written or predestined. Fatality.)
3. See E. Dermemghem "Vie des Saints musulamns." [The Lives of Muslim Saints] Baconnier, Algiers. p. 283 *passim*. Ed. Doutte: "Les marabouts." [The Marabouts] Leroux, Paris, 1900, p. 77.

Chapter 10

The Phenomenon of Agitation in Psychiatry: General Considerations and Psychopathological Significance*

At a conference organized by *Evolution psychiatrique*[1], Dr. Tosquelles distinguished two types of agitation: he opposed the *expressive type* to the *percepto-reactive type*. Such an opposition, interesting from a heuristic perspective or at least from a didactic one, seems wrong to us doctrinally. The same is true for the opposition between reactive and nonreactive agitation.

In fact, except for profoundly toxic agitation that severely effects consciousness, agitation is nearly always expressed in the percepto-reactive mode. That is to say, aside from typically neurological agitation of an automatic kind brought on by violent alterations of consciousness (such as epileptic seizures), agitated behavior is at once expressive and percepto-reactive. Clinically, we can distinguish predominantly motor agitation from predominantly verbal and verbal-motor types.

Idiots and imbeciles on the one hand, and the senile on the other provide an impressive enough array of purely motor agitation not including, of course, the explosive rage of the paranoid, hebephrenic impulses and the circumscribed agitation of catatonic patients. We are looking at agitation as a state here. We notice that the two conditions most conducive to the onset of motor agitation[2] both involve neurological defects. Such empty, idealess agitation produces stereotypy (for instance the pseudo-anxious pacing of the old or the shredding of clothing of oligophrenics).

Predominantly verbal agitation appears less neurological and hence more comprehensible. In fact, the incoherent soliloquy of an imbecile or the scattered verbigeration of a presbyophrenic are striking by their automatic, archaic, disintegrated, and somatic character. Finally, verbo-motor agitation is perhaps the most studied type precisely because it reconstitutes the basic melody of living man. Speech and action combined within a spatiotemporal structure seems to keep the organism within the realm of the comprehensible. This is perhaps why pure mania is the most studied clinical form of this type of agitation. In fact, verbo-motor agitation extends

12_Fannon_cha10.indd 107 10/7/2014 5:42:52 PM

well beyond the confines of mania. Hysterical manifestations and acute phases of multi-thematic active delusion take on the physiognomy of confused-enraged agitation; the anguished-ecstatic crises of Schneider evoke the manic spectrum on more than one level.

The parameters of these mixed states that Beringer insisted upon are so much looser that we feel justified in taking some liberty with regard to the classic equation "agitation = mania," at least for the sake of clinical observation. Having done so, we can easily advance the idea that a patient's behavior be understood as a function of the hospital ward and its possibilities of assimilation. Only once the hospital milieu has become a therapeutic tool, and above all, a general context for disalienating encounters has imperatively been instituted; only if the will to take responsibility for a living, agitated organism is present; only then can we begin to attempt authentically discerning between types of agitation.

Certain notions such as *psychose de façade* and *morbid mental persistence*, spectacular *reactions de prestance*, or provocations with *high* aggressive content of the kind found in penitentiary conditions, and the sadomasochistic nodes that so easily materialize in asylum settings, all require special vigilance.

A "benevolent neutrality" should be adopted here in its most genuine form. To think the hospital as therapeutic tool is to structure it, to allow the patient to "finally feel understood" rather than amputated or castrated by it. Elastic aggressiveness and what the staff interprets as "unprovoked malice" from patients are obviously responses to a prison-like structure, primarily repressive in kind. The hospital should indeed be able to handle a patient's pathological displays. The onset of agitation should not cause the collapse or breakdown of institutional equilibrium.

Agitation simply tests the degree of resistance of the hospital, determining both its plasticity and solidity. It is precisely when the agitated are not rejected, excluded, isolated, or confined that we can endeavor to understand them. The idea is certainly not to declare the abolition of all means of coercion because of some humanitarian or hetero-imitative impulse. This might open the door to problems that would give cause to the renewed use of modes of restraint with unbridled fervor.

More often than not, confining agitated patients has detrimental effects. Isolating a patient already confined to a psychiatric hospital is akin to a second internment. The social milieu has already rid itself of the mentally ill by appealing to the Law of 1838. And the demands of the social milieu are formal: a monolithic equilibrium must be maintained in the outside world regarding certain behaviors. The hospital environment however rarely presents any kind of organizational plan. The lines of force that participate in erecting its phenomenal field are disastrously wanting. Except for the biological rhythm of three meals a day followed by sleep, non-bedridden mental patients are mainly left to wander about the asylum courtyard in a Brownian-type motion. It soon enough becomes clear that repressive measures such as restraints are used on the initiative of the staff. And doctors often suspect them of engaging in sadistic behavior. A chain reaction takes place that vitiates the relationship between doctors and personnel: " No restraining the patient" says the doctor; "Doctor, the patient is running amok"; "Doctor, the patient has injured three staff members"; "Therefore, Doctor, we're going to restrain the patient," say the staff. The fact is that the hospital itself is sadistic, repressive, rigid, nonsocialized, and

12_Fannon_cha10.indd 108 10/7/2014 5:42:53 PM

castrating. Consequently, it is less a question of ordering the suppression of straitjackets or padded cells than of allowing productive, disalienating, functional lines of force to circulate with the potential to respond to differentiated exigencies.

Internment also provokes a primary disadaptation. Punitive isolation (dark isolation cell, punishment) and the fantasies it awakens (enabled moreover by the literal explanation offered by the staff: "if you continue, you'll be put in isolation or confined with the agitated patients") inevitably fail to calm the patient, which is the purported aim. Because of isolation, imposed solitude and motor constriction (we know the salience of the verbo-kinetic melody and the disruptions in corporeal schema that ensue from a disjunction) new symptoms appear. Verbo-motor agitation caused by isolation becomes enraged, predatory, elastic, and furious. Sometimes, instances of hyposthenic delusions of reference that are clearly manifestations of a response to reality and understandably related to the context are complicated by hallucinations.

Perhaps these provoked hallucinations should be the object of a separate study. Due to the dissolution of the organism on the one hand, and its reaction to it on the other, regression to an archaic kind of thought process ensues: more dense, more dependent on motor function, less discerning of sensory data. Psychoanalysis holds that oneirism, pseudo-hallucination, and the importance of play and mimicry appear mainly during the oral stage.

Logorrhea, the emergence of a whirlwind of atmospheric festiveness, a being-there deployed simultaneously at both poles of temporality, convey a staggering degree of orality; but also, an aggressive, vehement existence full of protestation and anxiety linked to infantile frustrations.

Insufficient attention has been given to the ease with which classic agitation devolves into hallucination. In fact, the flight of ideas prepares the way for verbo-motor hallucinatory phenomena. De Clérambault certainly understood this when he linked mental automatism to intuitions, anticipated thought, *echo de la pensée*, nonsensical words, explosive words, litanies and syllabic games. The hallucinatory process brings about the collapse of world = system of reference. Neither the time nor space of hallucination lays any kind of claim to reality. On the contrary, it must be said with Sartre that hallucination coincides with the brusque annihilation of perceived reality. Hallucinatory time is perpetually in flight. The spatiotemporal context of hallucinatory activity is without order, unreal, fictive. The phenomenon of belief, which psychiatrists have spoken of at length, is what legitimates the pseudo-reality of hallucinations in the eyes of the patient. Practically speaking, isolation, restraint, and the sadistic use of coercive methods provoke or at the very least precipitate and aggravate regression. The flight of ideas is *gripped* in a flux of images without the possibility of relying on the benevolent and actualizing presence of others to escape it.

Imprisoning, isolating, tying patients down to their beds creates all the conditions for the existence of hallucinatory activity. Clinical observation of hallucinations is "complicated" by the anxiety, isolation, and impression of psychobiological catastrophe characteristic of nearly all mental illnesses, compounded here by the type of aggression caused by rejection and exclusion.

12_Fannon_cha10.indd 109 10/7/2014 5:42:53 PM

Hallucination is thus not merely a product of cerebral excitation or any specific encephalic nutritional deficiency. It is rather a more general behavioral response, a reaction by the organism. Of course, hallucinatory responses presuppose dissolution, organic damage, or metabolic disorders but these alterations are never univocal. We must never forget that hallucination escapes mechanistic explanation, even though the work of MacFarland and Goldstein on the relationship of metabolic and emotional stability, and the work of Hoskins on the chronic paucity of oxygen in the brain caused by disturbances in enzymatic catalysis characteristic of schizophrenia should always be taken into account. For there to be hallucination something else must happen: the collapse of the real world. The phase at the heart of chronic hallucinatory delusion, which the Ancients called rumination, is quite eloquent in this regard. We know that after the onset of delusion marked by hypochondria, unusual bodily manifestations and unfamiliar visceral sensations, there occurs a phase of anxious rumination, exacerbated ideational concentration, interpretative suspicion, and aggressive solitude: this is already the pre-hallucinatory period said to be interpretative.

In reality, rejection of the real world is made possible by the emergence of a pseudo-world built on new relations and significations. The solemn decision (acute penetration stage) to reject the real world requires constant validation, confirmation, and fuel. Thus it is precisely the ambulatory patients who never quite manage to neutralize or shut out the existence of the world around them. From this perspective, isolation provides authorization to hallucinate.

Hospitals tend to reject agitated patients without understanding the fundamentally reciprocal relation that binds them. Agitation appears within the human context which is the hospital, meaning it must be understood dialectically not mechanistically. Even those who refuse this interpretation recognize that agitation diminishes as a function of the education of the staff and the disalienating nature of the milieu, however superficial. Agitation may thus be seen as the gangrene of the asylum. As Parchappe writes: "many years of experience in many different contexts have demonstrated that permanent confinement to a cell, far from being an efficient means of appeasement for the mentally ill, has the contrary effect of augmenting and maintaining agitation."

When the hospital becomes a nexus of social relations and ambiguous encounters, agitation loses its sense of seclusion, irresponsibility, and incomprehensibility. From a dialectical perspective, agitation then reenters the primordial cycle of mirror reflection: you give; I receive, assimilate, transform, and give back. Although destructive reactions such as agitation do not just disappear, the signifying value of the organism's attempts at explanation is restored and a second internment or isolation is rejected once and for all.

The hospital is transformed in a lucid, conscious manner into a rolling mill, a purifier. These notions of rigorous competency, robust flexibility, and articulated institutions break the vicious circle in which the patient tends to be caught from the very beginning. The self-imitation and autointoxication that takes place in isolation is now framed within a context of open institutions. And by engaging with this kind of institution, consciousness is freed from the downward spiral in which it was trapped.

12_Fannon_chal0.indd 110 10/7/2014 5:42:54 PM

The pathological reality and its basic symptoms continue to challenge the institution however. There is no way that hebephrenia or hyposthenic paranoia can be cured simply by the play of emotional-affective investments made possible by the reorganization of the hospital. In addition, keeping agitated patients in the larger hospital milieu may cause distress in other patients and staff due to their turbulent presence. Janet, in his *Médications psychologiques*, particularly insists on the injuriousness of such a scenario.

Instead, a well-organized hospital should highlight the residual tableau and as Ey puts it, bridge the organo-clinical gap. Lessening this gap as much as possible is the hospital's main task: its pre- and para-therapeutic task.

It is worth mentioning that understanding the necessity of reorganizing the hospital, of institutionalizing it and making it possible to carry out social relations within its walls must not give way to mystification based on external references. One often hears expressions such as:

- The hospital as village
- The hospital as reflection of the outside world
- Being in the hospital is just like being out; the patient should be at home...

Clearly, these kinds of sayings are attempts at masking reality under falsely psychotherapeutic humanitarian concerns—and Le Guillant is absolutely right to condemn such attitudes as unrealistic. In addition, if the hospital *is* the outside world, a strong tendency to legitimate it by establishing for it systems of maintaining equilibrium like those on the outside will inevitably appear. The doctor's lock up unexpectedly meets the head of service's punishment to go without desert or the dining hall attendant's threat of transfer to the agitated or incontinent wards.

Agitation is a foreign body for the institution but so are the mentally ill. The hospital should allow the reconciliation between the living and its manifestations. It should never reject anything coming from a patient. Patients have nowhere else to turn outside of the hospital. Paradoxically, the hospital is the last resort of both the social group that seeks to rid itself of the mentally ill and of the patient seeking *his* own lost signification. Consequently, it cannot only be a question of calming agitation. Telephone consultations or quick and easy prescriptions of Sédol or Largactil show a complete lack of understanding of pathological mechanisms.

Agitation is not merely an excrescence or "psycho-motor" cancer. It is also and foremost a mode of existence, a kind of actualization, an expressive style. Agitation is disarming for its capacity to reunite structures. It can appear at any level of dissolution. This kind of equivocal phenomena is bound to provoke disastrous reactions. Thus the "agitated-who-knows-what-he-does" is put in the same cell as the "agitated-who-knows-not-what-he-does." In reality, the agitated both knows and does not know what he does simultaneously; or better, he does not know but tries to find out. These attempts at finding out shed light on certain aspects of the situation while keeping others in the dark, leaving the observer with the uncomfortable feeling of being mystified. Thus the fundamental ambiguity of human existence is integrally lived and expressed, even through the most disordered and anarchic of behaviors, too easily stamped as nonsense.

12_Fannon_cha10.indd 111 10/7/2014 5:42:54 PM

Notes

* In collaboration with S. Asselah, first published in *Marcoc Médicle* vol. xxxvi, no 380.

1. TR: *Evolution psychiatrique* is a journal that was created in 1929 and meant to be a crossroads for medical psychiatry and psychoanalysis. They also organized conferences in which Dr. Tosquelles was very active in the 50s. This is probably a reference to the paper "Introduction à une semiology to l'agitation" later published in *Evolution psychiatrique*, no.1, 1954.
2. TR: severe retardation and senility.

12_Fannon_cha10.indd 112 10/7/2014 5:42:55 PM

Chapter 11

Letter to the Resident Minister*

Monsieur le Docteur Frantz FANON
Médecin des Hôpitaux Psychiatriques
Médecin-Chef de service à
L'Hôpital Psychiatrique de
BLIDA-JOINVILLE

à Monsieur le Ministre Résident,
Gouverneur Général de l'Algérie

ALGER

Monsieur le Ministre,

Upon my request and by the decree dated October 22, 1953, *Monsieur* the Minister of Public Health and Population was good enough to put me at the disposal of *Monsieur* the Governor General of Algeria for appointment to a Psychiatric Hospital in Algeria.

I have exercised the functions of *Médecin-Chef* since I took up my post at the Blida-Joinville Psychiatric Hospital on November 23, 1953.

Although the objective conditions under which psychiatry is practiced in Algeria already defied reason, it seemed that efforts should be made to lessen the viciousness of a system based on doctrines opposed to any authentically human perspective in the day-to-day.

For close to three years, I put myself wholly at the service of this country and its inhabitants. I spared neither effort nor enthusiasm. Not one of my actions that did not set as horizon the unanimously desired emergence of a decent world.

But what good are enthusiasm and care for the human if reality is spun out of lies, cowardice, and contempt for the human on a daily basis?

What good are intentions if their incarnation is made impossible by indigence of the heart, sterility of the mind, and hate for the natives of this country?

13_Fannon_ch11.indd 113 10/7/2014 5:41:02 PM

Madness is one of the means by which man can lose his freedom. And, I can say that, from the crossroads where I stand, I have measured with horror the magnitude of alienation in the inhabitants of this country.

If psychiatry is the medical technique that proposes to help man no longer be a stranger to his environment, I can only but confirm that the Arab—permanently alienated within his own country—lives in a state of absolute depersonalization.

What is the status of Algeria? A systematized dehumanization.

Whereas the absurd wager was to instill certain values, no matter the cost, despite the fact that lawlessness, inequality, and the daily multifarious murder of the human were elevated to the status of legislative principle.

The social structure in place in Algeria stood against any attempt to return the individual to his rightful place.

Monsieur le Ministre, there comes a time when tenacity becomes morbid perseverance. Hope is no longer a door open unto the future but the irrational preservation of a subjective outlook in organized rupture with the real.

Monsieur le Ministre, the recent events that are making a bloodbath of Algeria do not constitute a scandal in the eyes of the observer. They are neither accidental nor the result of a breakdown of the apparatus.

The events of Algeria are a logical consequence of an aborted attempt to decerebralize people.

There is no need to be a psychologist to divine a fundamental demand for dignity under the apparent good nature and dispossessed humility of the Algerian. And there is no sense appealing to some form of civic conscience in light of these irreducibly complex demonstrations.

The function of a social structure is to set up institutions permeated by care for the human. A society that forces its members to take desperate measures is a non-viable one, a society to be replaced.

A citizen's duty is to say so. Neither professional morality, nor class solidarity, nor a desire to wash the family laundry in private prevails here. No pseudo-national mystification will be favored over the demands of reason.

Monsieur le Ministre, the decision to punish the strikers of July 5, 1956, seems to me quite literally to be an irrational measure.

Either the strikers had been terrorized in their own flesh and that of their families, in which case their behavior should have been understood, *judged normal in light of the situation.*

Or their abstention was the manifestation of a unanimous current in public opinion, an unwavering conviction, in which case any punitive response was superfluous, gratuitous, and inoperable.

I owe it to the truth to say that fear did not appear to me the dominant feeling amongst the strikers. Much greater was the ineluctable determination to kindle, in calm and silence, the dawning of a new era full of peace and dignity.

13_Fannon_ch11.indd 114 10/7/2014 5:41:02 PM

A worker must participate in the social manifestations of the polis. But he has to be convinced of the greatness of the society he lives in. There comes a time when silence becomes dishonesty.

The motivations that govern personal existence have difficulty sustaining a permanent assault on the most basic of values.

For many long months my conscience has been the seat of unpardonable debates. And the result is my determination not to despair of the human, in other words, of myself.

I have decided not to continue performing my duties at whatever the cost, on the fallacious pretext that there is nothing else to be done.

For all of these reasons I have the honor, *Monsieur le Ministre*, of asking that you be good enough to accept my resignation and put an end to my mission in Algeria.

Respectfully yours

Note

* First published in the Maspero collection "Cahiers libres" in 1964, though this translation is from the original letter attached to the police intelligence report appended in this volume. See p. xx.

13_Fannon_cha11.indd 115 10/7/2014 5:41:02 PM

13_Fannon_ch11.indd 116 10/7/2014 5:41:03 PM

Appendix: Police Intelligence Service Personal File on Dr. Fanon

Government General of Algeria
Department of National Security in Algeria
Blida, November 8, 1956

FROM: The Police Chief of the PRG Precinct of Blida[1]
TO: *Monsieur* the Sub-Prefect of Blida

OBJECT: Personal File on Dr. Fanon

I have the honor of addressing to you the attached personal file on Dr. Fanon, chief physician responsible for the Reynaud Pavilion at Blida Psychiatric Hospital.

Signed: P. le Vaillant
cc: Divisional Police Commissioner, Chief of the Algiers District PRG

PERSONAL FILE
Last Name: FANON
First Names: Frantz Marguerite Victor
Born: 20 July 1925
In: Martinique
Family situation: Married – 1 child
Residence: Blida Psychiatric Hospital
Profession: Doctor of Medicine, *Chef de service* H.P.B.
Previous residence: Pontorson Hospital (Manche region)

INFORMATION

Subject is close to Dr Lacheraf with whom he shares nationalist ideas.

Subject is designated as the organizer of the UGTA union of the HPB (reconstituted, previously known as CGT) not yet officially registered. It has preserved the communizing tendencies of its forbearer.

14_Fannon_chal1app.indd 117 10/7/2014 5:38:31 PM

Subject is very close to the Counillon couple (the husband is currently in training as an H.L.L.)[2]

Subject supported the strike action of 5.7.1956 in his service and refused to apply sanctions to the strikers under his responsibility.

This explains why the highest percentage of strike followers was recorded at the Reynaud Pavillion under Dr. Fanon's authority.

Subject is the coauthor of a letter addressed to the Director of the Institution, letter in which three HPB doctors threatened to resign if disciplinary measures were taken subsequent to the 5.7.1956 strike.

Subject is the instigator of the petition launched in protest of the administrative internment of Abdelkader Hanachi, Union Secretary (it is claimed that Dr. Fanon is the one who advised Miss Tramoni and Mr. Allil, authors of the petition.)

Regarding a military operation that brought about the death of a French-Muslim, subject systematically and with no concern for objectivity, took a position contrary to the real version of events.

Subject is the author of a letter addressed to Mr. the Resident Minister, Governor General of Algeria, in July 1956,[3] a letter that contains an indictment of French policy in Algeria.

Notes

1. TR: PRG stands for *Police et Renseignements Généraux* [Police Intelligence Service]
2. TR: HLL stands for *Hors-la-loi indigène*, a term used by the French to designate FLN and ALN combatants.
3. TR: The letter to the Resident Minister, appended to this report, was written in November not July, 1956.

14_Fannon_chal1app.indd 118 10/7/2014 5:38:32 PM

Chapter 12

Day Hospitalization in Psychiatry: Its Value and Limitations*

General Introduction

Since the end of World War II, psychiatric practitioners in many different countries have had to face acute problems in the administration of care. Even before 1939, priority was given to prevention and early diagnosis of mental illness on the one hand, and simplifying the administrative formalities linked to hospitalization on the other.

To cite but one example, a law was passed as early as 1938 in France to eliminate the carceral character of psychiatric asylums. During the war, the sudden rise of mental illness led Anglo-Saxon doctors to generalize "open-door" practice within psychiatric hospitals. This open-door formula, inaugurated by Duncan Macmillan in Nottingham and since adopted in several different countries, granted patients more freedom within the hospital, maximizing contact between patients and their social milieu: family visits, leaves of absence, vacations, early and probationary releases.

Although the first patients to benefit from this "open-door" policy were neurotics and pre-psychotics, studies of chronic patients have shown that a majority of their early symptoms are in fact of the neurotic type. Paradoxically, the asylum tends to aggravate these symptoms and favor the onset of psychosis. Thus it was only a matter of time before the idea of a "day-hospital" was launched with the most conclusive results documented in England, Denmark, and Canada.

What are the principles of day hospitalization?

a) First, patients are not cut off from their family or professional milieus.
b) Second, psychiatric symptoms do not disappear with internment, since the elements of conflict (the conflictual configuration) remain present and very much alive in familial, social, and professional contexts.

Manifestations of stress do not magically disappear as they often seem to after internment, thus affording us access to patient reactions within their normal environment.

In the old psychiatric hospital setting, patients were removed from conflictual contexts, often giving the impression that neurotic symptoms suddenly disappeared as soon as the asylum doors were shut. We could thereby claim that internment provided release. Yet neurotic behavior continued and its abreaction observed every time wife or husband visited or mention was made of past difficulties. The asylum extended a protective mantle over the patient, yet its protection was false as it merely provoked lethargy—a state of "waking sleep" in which the patient would lead a vegetative life. And only the behavioral disorders derived more often than not from living conditions in the asylum would attract the attention of the doctor.

Attempts made to create a neo-society within the hospital (experiments in social therapy) sought to avoid this by imposing situations from the outside world on patients who would then be able to adjust their neurotic responses as they were played out in context. Day hospitalization, then, responds to two pressing needs:

a) Preventative diagnosis and treatment of behavioral problems
b) Maintaining maximum contact between patients and the outside world such that neurotic behavior and conflictual situations do not magically disappear. It is not a matter of extracting the patient from social life but, rather, of instigating therapeutic work within that context.

From the perspective of psychiatric care, day hospitalization is an attempt to undo the apparent sense of security the asylum offers. However, these experiments are rare. There are at most 20 day-hospitals in the world, each in a technologically advanced nation. Never has day hospitalization been attempted in an underdeveloped country. It was therefore important from a methodological standpoint to ask two things: first, whether day hospitalization was feasible in a less-industrialized nation. And if so, a doctrinal consideration: could day hospitalization respond to all psychiatric conditions? In light of this, the Tunisian government's decision to create the only existing Center for Day-Neuropsychiatry on the African continent is highly commendable.

The results of this experiment will be examined below and a case made for day hospitalization, even in underdeveloped countries. It is our conviction that it is henceforth both medically important and socially worthwhile to develop Centers for Day-Neuropsychiatry in these countries. As we shall see, the Center for Day-Neuropsychiatry received and treated more than 1,000 patients in 18 months and less than 0.88 percent required full hospitalization.

The Tunis Center for Day-Neuropsychiatry

The Charles Nicolle General Hospital was home to a neuropsychiatric ward created more than 40 years ago and almost entirely governed by the Law of 1838[1]—the

only difference being the relative priority given to voluntary patients that qualified for open-door care. Surveillance measures were akin to those practiced in the worst kind of basic psychiatric unit: straitjackets, solitary confinement, bars, locked doors and, especially, the complacently punitive outlook of the institution. When asked by the Ministry to produce a report on the overall state of psychiatric care in Tunisia, Tunisian psychiatrists unanimously argued against multiplying big hospital-like psychiatric facilities that would sooner or later be transformed into asylums. They insisted, rather, on the need to create low capacity neuropsychiatric wards within already existing general hospitals where therapeutic efficacy could be rationally analyzed and augmented. And since the Charles Nicolle Hospital was already up for a thorough reorganization, they proposed to immediately launch the experiment by transforming the existing neuropsychiatric ward into a day service.

Architectural modifications were minimal. We primarily focused on adding handles to doors, removing bars from windows and getting rid of restraints of the straitjacket and handcuff variety. A team of patients was charged with demolishing the solitary confinement units. The building was repainted and hospital capacity limited to 80 beds: 40 for men, 40 for women. In the women's unit, a small cubicle with 6 beds was reserved for children.

There was a serious personnel problem however. The existing staff had developed certain habits where repression dominated. Like in a good number of asylums to date, patients were considered a source of annoyance and unpleasantness. And as usual, the professional adage that would have patients be the end all of the hospital was inverted. Instead, they were made into enemies of the staff's peace and quiet. This critique is certainly not specific to the Charles Nicolle staff since one of the main criticisms leveled at the very concept of the asylum over the past 20 years has precisely to do with the sadomasochistic relations that progressively take root between nurses and patients.

A supervisor managed the personnel (5 women, 6 men). Classes were promptly proposed in order to break with the old ways and introduce new ones that supported the new concept. It soon became clear that certain nurses were unable to adapt quickly enough and so, with the approval of the ward doctors, they requested transfers and were replaced by a younger, better educated staff who had never before worked with psychiatric patients.

A Day at the Center

Patients start arriving at 7:00 a.m., either alone or accompanied by family. The nurses are already in place and ready to welcome them. Each nurse is responsible for 6 to 8 patients for the entire course of treatment. Every day begins with nurses giving their patients a routine physical examination (checking temperature, pulse, and blood pressure) followed by an interview to gather information on the patient's activities and thoughts from the moment he left the center the night before until his return. Nurses are asked to pay close attention to sleep patterns, marital relations

15_Fannon_cha12.indd 121 10/7/2014 5:39:04 PM

(if married), nightmares, and dreams. A report is prepared for the doctor every morning. Nurses are asked to adopt a benevolent attitude toward patients, especially when their dream content was particularly distressing the night before, in which case the doctor is informed immediately upon arrival.

Three days are devoted to the men's unit and three to the women's[2] but more often, the physician will intervene immediately when informed of a particularly anxious patient or one whose family troubles took a sharp turn for the worse the night before.

Two types of psychotherapy are practiced at the Center:

a) Principally, psychoanalytically inspired psychotherapy
b) Auxiliary therapy providing support and explanation, primarily inspired by Pavlov's Second Signal System.

In the second case, the patient's attributed nurse will most often be present for the session.

As a general rule, nurses avoid questioning family in the presence of the patient, especially regarding the patient's behavior, in order to avoid any awkwardness. Sometimes patients are so inhibited that it is impossible to obtain information about their lives outside the center. In these cases, family members are questioned.

Lunch is served between 11:30 a.m. and 12:30 p.m., like in the hospital's other wards. Afternoons are devoted to collective activities such as drama therapy: nurses meet with their group of patients and either tell them a story, noting projections and identifications, or individual patients are asked to recount their problems while the group's reactions are noted (we will return to the value of this method in the chapter on psychotherapy). Other activities might also be scheduled like crafts for men and knitting, sewing, ironing, and cooking for women; or initiation sessions on how to care for babies or use a sewing machine or iron. An evening meal is served at 5:00 p.m. and patients begin to leave the Center around 5:30 p.m. The Center closes at 6:00 p.m. and is also closed on Sundays.

Part-Time Hospitalization

It often happens that individuals require psychiatric care while their material conditions do not allow them to leave their jobs or otherwise interrupt daily activities. This is true for housekeepers, students, and sales representatives for example. In this case, patients are allowed to leave the Center once the initial treatment is completed. The problems of occupational therapy in the asylum context are thereby resolved in the best possible way as patients do not lose touch with the context of their praxis or risk losing their professional skills for lack of use. It does not feel unrealistic then to take the next step and address another problem we find critical. Would it not be feasible to follow the example set elsewhere and organize a night service after 6:00 p.m. for persons operating in specific social contexts (civil servants, teachers, artisans) to receive treatment without interrupting their professional activities?

* * *

As previously mentioned, the Tunis Center for Day-Neuropsychiatry opened its doors in May of 1958. From May to December of that year, 345 patients were admitted with the following distribution:[3]

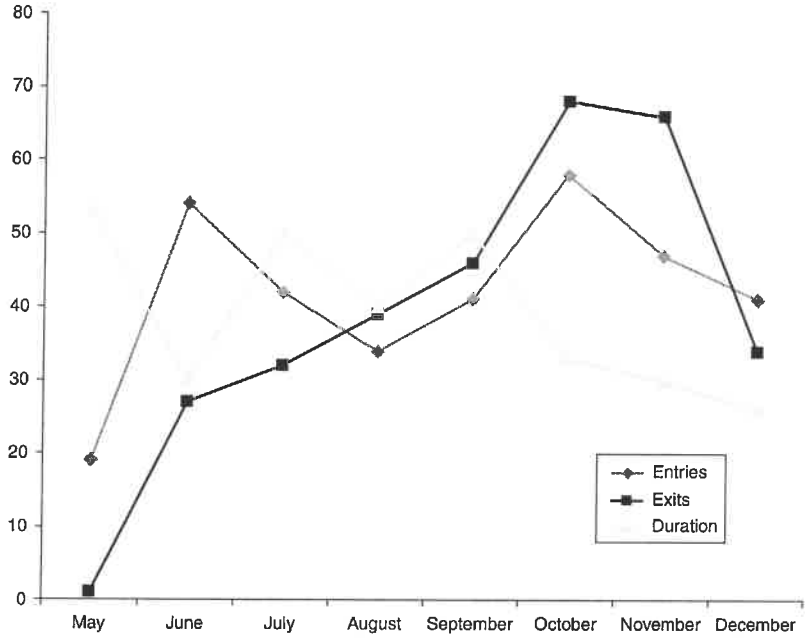


Figure 12.1 Duration of patient stay at the CNPJ.

This averages to around 57.5 patients per month.

Based on the curve of average stay (figure 12.1), we notice that the average in the first month was 53 days, a figure which was never surpassed. By December, it had fallen to 26 days, clearly demonstrating steady improvement in the organization of the ward.

There were by far more men than women and only a small number of children because we chose to focus our efforts on adult care to begin with. Only later were we able to provide a children's section. After 1959, children were admitted in significant numbers.

Amongst the 345 patients hospitalized at the CNPJ during the first six months of 1958, there were 12 Israelites (6 men, 6 women), 9 Europeans (8 men, 1 woman), 28 Algerian refugees (20 men, 8 women), and 296 Tunisians.

Average Age of Patients

Figure 12.2 shows that the majority of patients were between the ages of 15 and 35, with a peak between 20 and 25 years of age for both men and women. This figure

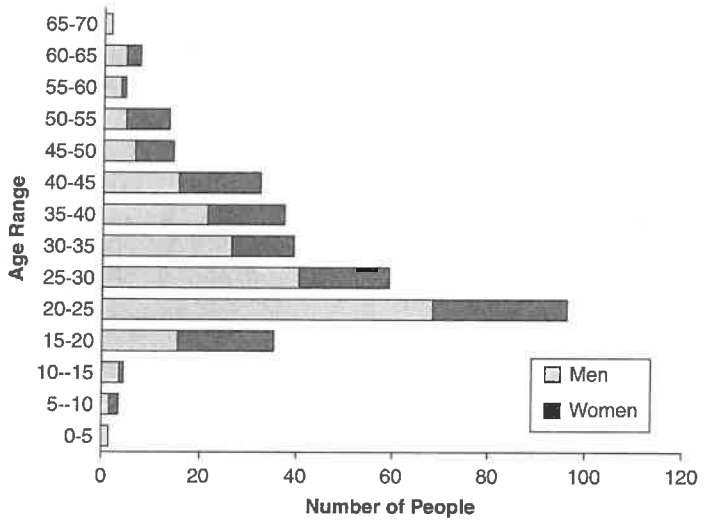


Figure 12.2 Patient age pyramid (1958).

is particularly interesting as it indicates that mental illnesses emerge precisely during the period considered by generalists to be the least exposed to illness. However, psychiatrists think of this age category as the emancipation of the individual, during which professions are chosen, homes are made and families started.

It is also remarkable how rare mental illnesses are during the post-menopausal period, as well as the quasi-absence of senility.

Family Context

Certain observations can be made depending on whether patients were single, married, married with children, or married without children. Of the 345 patients, 162 were single (115 men, 47 women). There were many more married patients with children than married without children: 105 (54 men, 51 women) to just 28 (14 men, 14 women.)

It is clear that the 115 single men were of marriageable age but were either unemployed or earned such dismal wages that it was impossible to start a household (figure 12.3).

Similarly, those married with children often found their material conditions to be so dire that providing for and raising children became dramatically difficult.

The Economic Condition of Male Patients (figure 12.4)

Of the 202 men hospitalized during the six months of 1958, 41 were small artisans (weavers, candy sellers, traveling vegetable salesmen, etc.) and 39 were

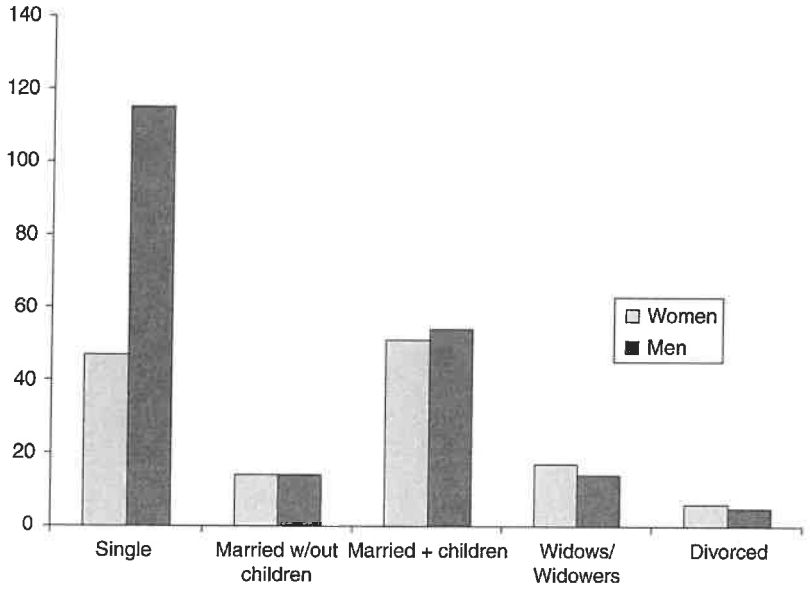


Figure 12.3 Family context: comparing men and women.

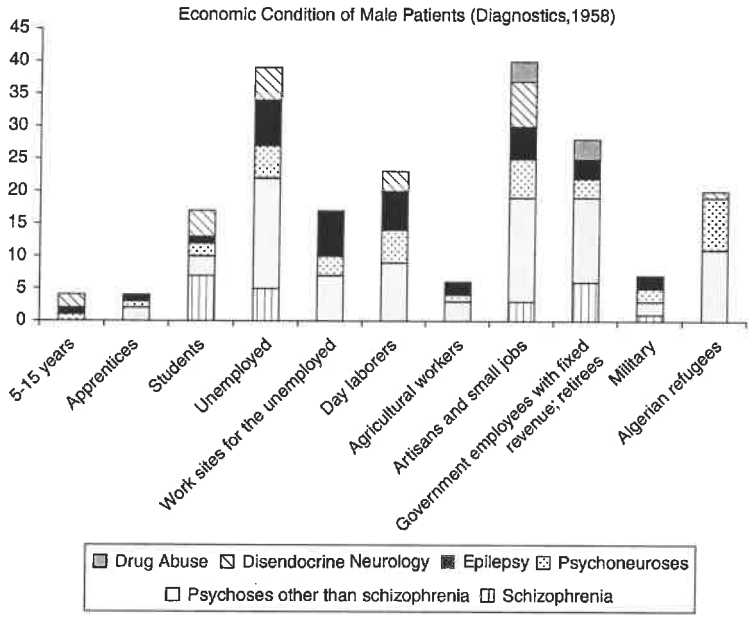


Figure 12.4 Economic condition of male patients (diagnostics).

unemployed, accounting for the two peaks on the graph. These figures point to a constant in the problematic of mental illness: uncertainty about the future and material hardship favor the onset of disequilibrium in individuals, thereby hindering harmonious integration into the group. It is also relevant to note the presence of 20 Algerian refugees. We will see that their numbers grew considerably in 1959.

The Economic Condition of Female Patients

Very few female patients held jobs. Of the 135 treated, only 4 were regularly employed (2 housekeepers, 2 servants.) Of the 65 married women, most had husbands that were day laborers or unemployed (figure 12.5).

Geographic Situation

195 patients were from the city of Tunis, 53 from the suburbs, and 51 from shantytowns (Djebel Lhamar: 16, Ras Tabia: 6, Melassine, Saïda-Manoubia: 21, La Cagna: 3, Le Borgel: 5.) (figure 12.6).

Sometimes patients living in other districts were able to find housing with family in Tunis. This was the case for 46 patients.

It would have been interesting to know how many of the 195 patients living in Tunis were born in Tunis and if not, how long they had been here; if they lived here permanently or periodically; if they came for work or pleasure. This kind of precision was difficult to obtain initially but we plan to request more information at a later date.

Diagnosis

Contrary to what we might assume, psychoses (including schizophrenia, chronic hallucinatory psychoses, manias, melancholia, and paranoia) were not the exception at the CNPJ. Out of 337 cases there were in fact 129 psychoses other than schizophrenia and 34 schizophrenias. Psychoneuroses, conversion neuroses, anxiety hysterias, obsessional neuroses, sexual perversions, etc., only figured in 74 cases.

Note the relatively large number of epileptics (47) however (see figures 12.5 and 12.6)

1959

670 patients were admitted to the CNPJ during the 11 months of 1959. Average stay continued to fall, hence an exceptional 15-day average in November.

The male-to-female ratio stayed close to the 1958 figure (232 women for 322 men) with, however, a net increase in number of children for a total of 116 (69 boys, 47 girls.) The children were often referred to us by schools or families for infantile encephalopathies, learning disabilities, stuttering, bed-wetting, etc. (figure 12.8).

15_Fannon_cha12.indd 126 10/7/2014 5:39:11 PM

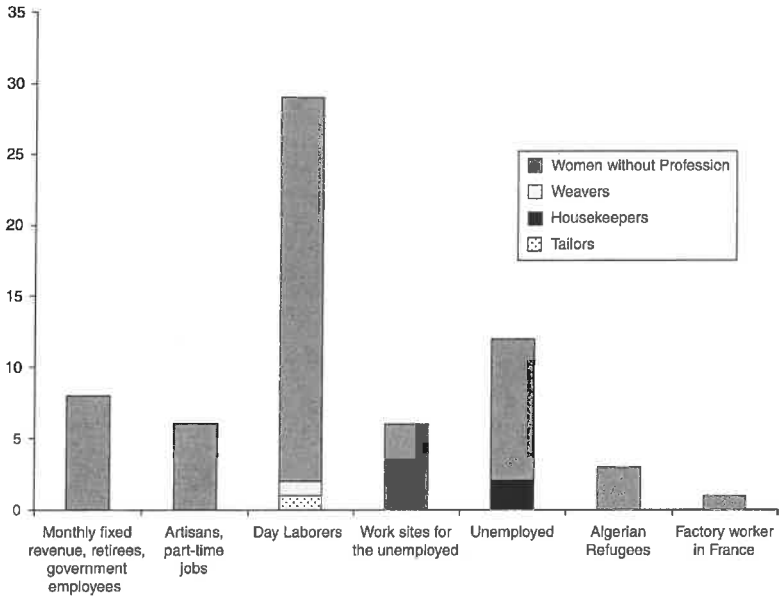


Figure 12.5 Economic condition of female patients by profession of the parent or her husband.

Average Age

In 1959, we found the same figures regarding patient age, confirming the fact that mental illness appears between the ages of 20 and 35. The saying *plus on vieillit mieux on se porte* should probably be reformulated: *plus on vieillit mieux on se supporte*[4] (figure 12.9)

Family Context:

Again in 1959, there were 274 single patients and 213 married with children. Those who were married without children, widowed or divorced, constituted a minute fraction of the Center's population (figure 12.10).

Economic Condition of Male Patients

Significantly, the diagram shows a high number of Algerian refugees (95), more than a sixth of the population. The pathology of the refugee is polyvalent and always very serious. We will address it in a forthcoming work. As for the other categories, note the high number of school-age children and, of course, the unemployed and small tradesmen (figure 12.11).

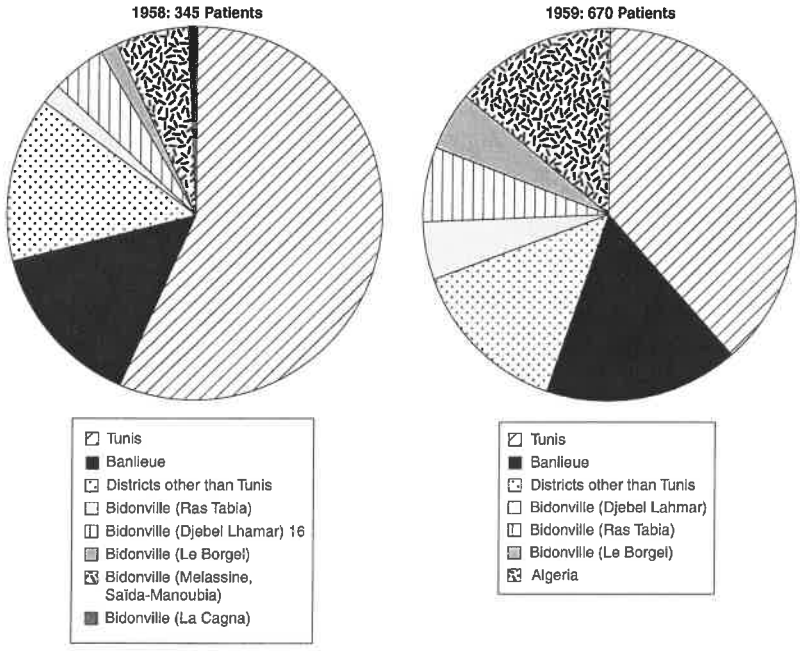


Figure 12.6 Geographic situation of patients.

Economic Condition of Female Patients

Most of the women did not have jobs. Only widows and divorcées worked for obvious reasons. Also, the majority of women hospitalized had unemployed husbands (figure 12.12).

Geographic Situation

As should be expected, the majority of those hospitalized at the Center lived in Tunis. Contrary to what we might expect however, a greater number of patients were from Tunis itself than from the shantytowns. Attention should also be drawn to the large number of Algerian refugees suffering from mental illness, surpassing the number of Tunisian patients from districts outside of Tunis (95 to 93) (figure 12.6).

Diagnosis

Note that there is still a large number of psychoneuroses and psychoses. In 1959, we also noticed the appearance of many infantile encephalopathies and neurological cases at the Center (figures 12.11 and 12.13).

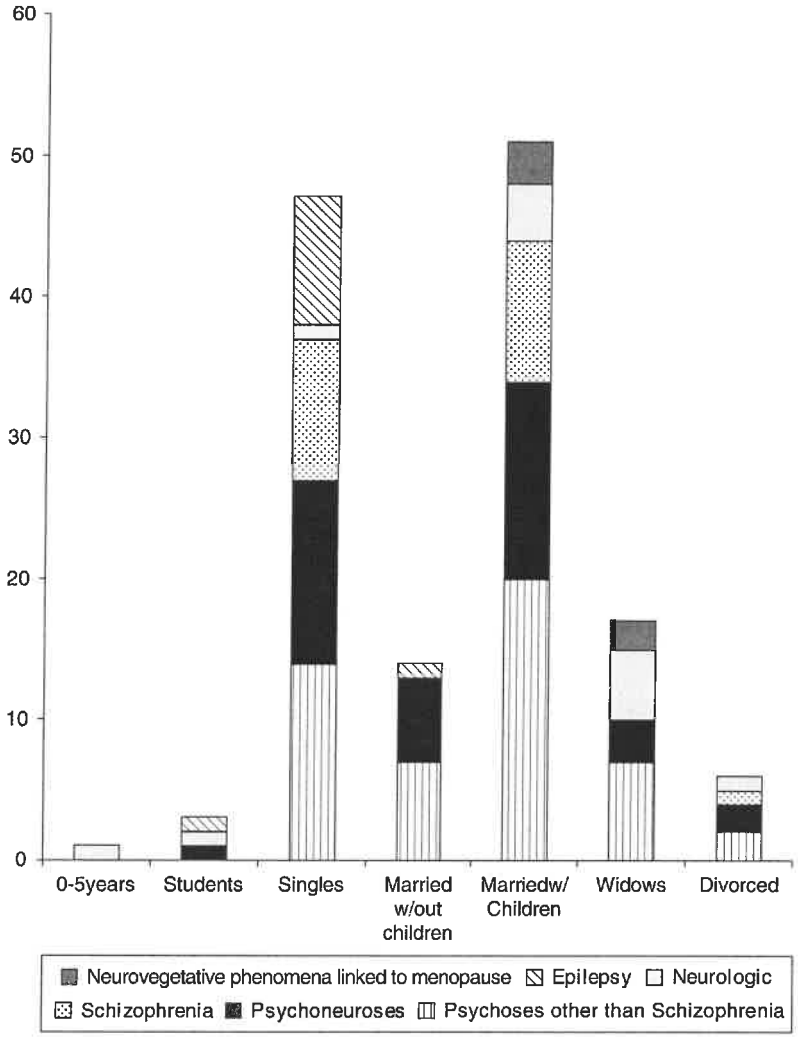


Figure 12.7 1958 Diagnostics.

Therapeutic Activities of the Center

(A) Insulin therapy

During the course of the last 17 months, 171 patients were treated with insulin therapy: 84 pre-comas (insulin shock therapy), 87 classic Sakel cures (insulin

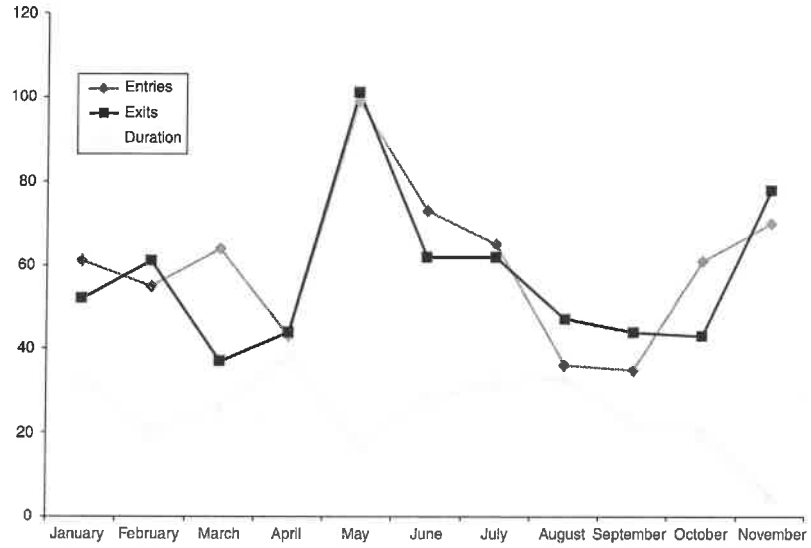


Figure 12.8 Duration of patient stay at the CNPJ (1959).

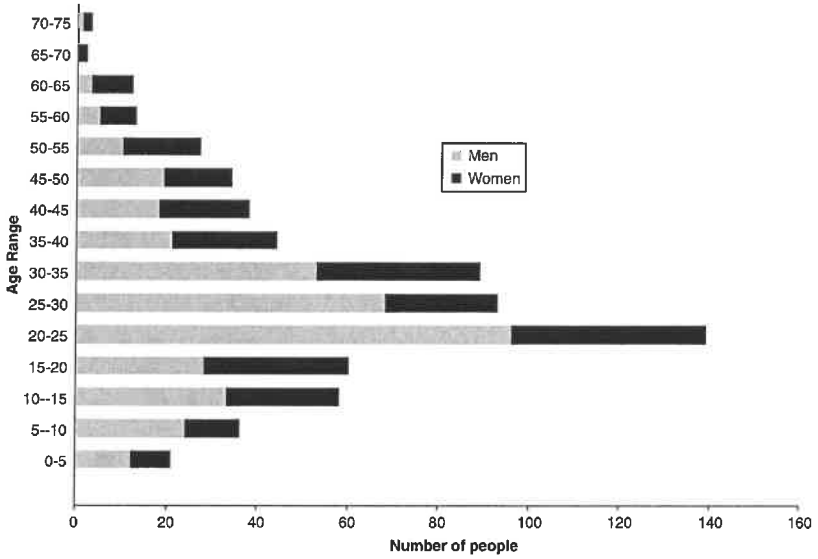


Figure 12.9 Patient age pyramid (1959).

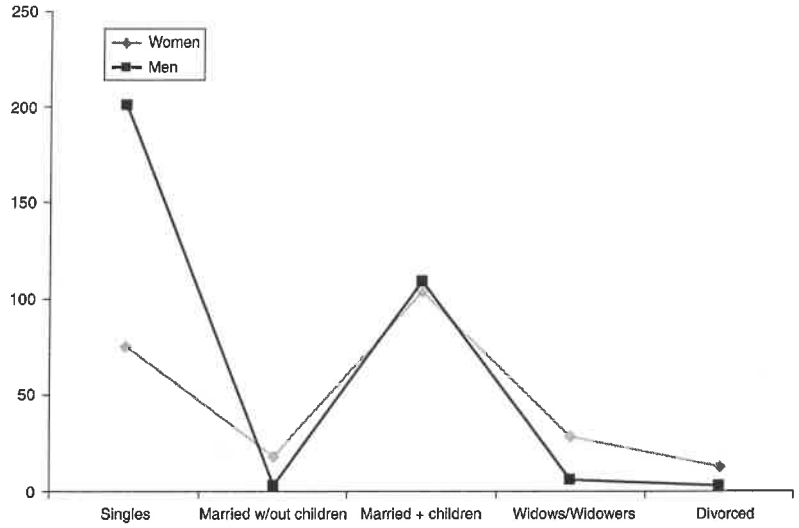


Figure 12.10 Family context: Comparing men and women (1959).

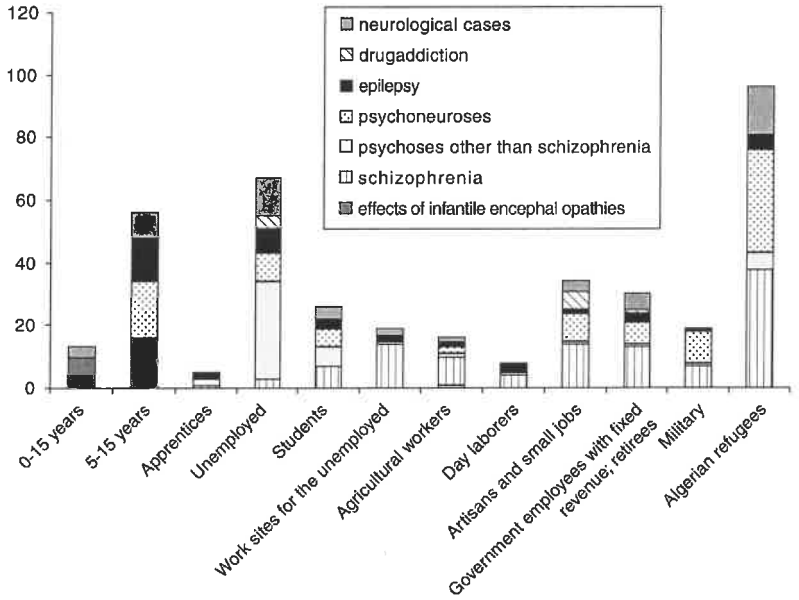


Figure 12.11 Economic condition of male patients.

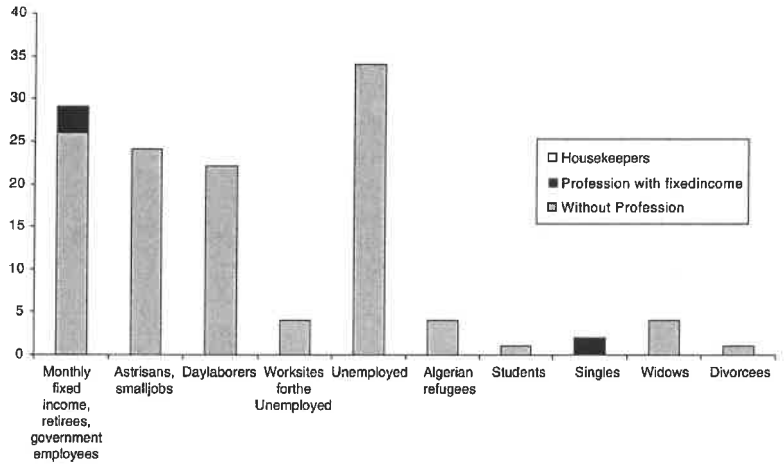


Figure 12.12 Economic condition of female patients.

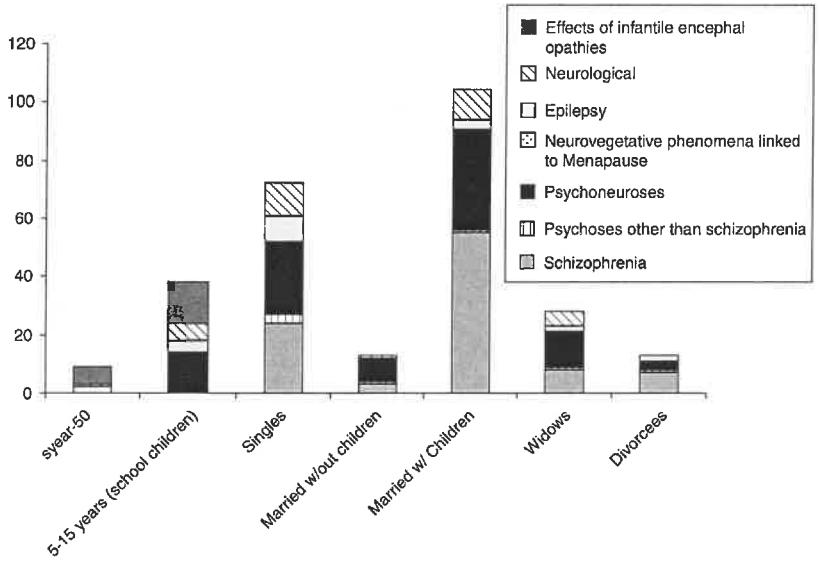


Figure 12.13 1959 Diagnostics.

coma therapy.) On average, these patients underwent 45 comas and 35 insulin shocks.

From a practical standpoint, insulin therapy in the context of day hospitalization poses certain problems. For instance, patients often forget to fast before treatment so

the physician must be very vigilant at the beginning of treatment as this could lead to insulin resistance, even when significant doses are administered.[5] Sometimes, a patient will begin to fast all of a sudden, once the dose of insulin administered is already elevated. Such cases should be anticipated. Hence particular vigilance is required of the personnel in charge of administering the therapy.

Patients should regain full consciousness with enough lucidity to leave the Center and return home unaided at the appointed time. Another problem encountered was patients slipping back into a coma after leaving the hospital. On the whole, these were rare and always minor incidents: 4 in 1958 and 1 during the 11 months of 1959. Instructions were always given to family members beforehand so that hardly ever did a physician have to be called in. The family member was able to immediately administer the required sugar dose. One rather serious incident did occur in 1958—a case of cerebral edema—requiring the patient to stay overnight at the Center.

Amongst our main concerns loomed the specter of Ramadan, during which patients stay up quite late, hence tiring the cortex, and accumulating such sugar reserves as to make a hypoglycemic coma practically impossible to trigger. In practice, however, we noticed that the evening festivities held such importance for patients that emotional factors and affective investment more than compensated for the minor inconveniences noted above.

It is also worth mentioning that we have never observed at the Center the kinds of agitated awakenings with high levels of aggression so typical of psychiatric hospitals. In fact, we don't think it overly idealistic to assume that patients never lose sight of the fact that they must leave at 5:30 p.m. Patients do not abandon their sense of self but maintain a constant level of self-awareness and composure. The lethargic, dull, obtuse, and limp patients typically found under insulin therapy in asylums are not to be found with day hospitalization.

(B) Sleep and Relaxation Therapy

There are five single rooms allocated to sleep therapy in each ward. Upon arrival, the patient is served a copious meal of over 1,200 calories. Medication is administered once the meal is finished and in principle, the patient sleeps until 4:30 p.m. The sleep cure then extends from 8:30 a.m. to 4:30 p.m. with a 15-minute break at 12:30 p.m. From 4:30 p.m. to 5:30 p.m., the patient is awakened and cared for and varying doses of neuroleptics are prescribed for the night. Once or twice a week, the patient engages in a psychotherapeutic session with the physician immediately after the morning meal and before sleep. Cures last for two to three weeks. In less severe cases, relaxation therapy is prescribed, primarily with the help of neuroleptics. The same principles apply and duration of treatment is largely the same as for sleep therapy.

(C) Neurology

Since there is no neurology ward at the Charles Nicolle Hospital, patients with neurological conditions are treated at the Center for Day Neuropsychiatry. These

15_Fannon_cha12.indd 133 10/7/2014 5:39:19 PM

include multiple sclerosis, tertiary syphilis, brain tumors, etc. Of particular interest to us are the more than 70 pneumoencephalographies performed at the Center: this investigative method was used equally with men, women, and children and all patients were able to leave the facility in the afternoon and return the following day. Since we were able to perform pneumoencephalographies, then it goes without saying that a significant number of spinal taps were performed without incident. These methods were instrumental in diagnosing 13 brain tumors.

(D) Electroconvulsive Therapy

Of the 1,000 patients admitted to the Center during its first 17 months, 72 were treated by electroconvulsive therapy. In general, we use simple electroshock therapy only to unblock the patient or sever an anxiogenic circuit that has proven difficult to treat otherwise. The overall average of sessions never exceeded three and few injuries were incurred except for some dislocated shoulders.

(E) Psychotherapy

The guiding principle for our psychotherapeutic interventions is to avoid, as far as possible, assaulting the patient's consciousness. Hence we rarely use narcoanalysis or amphetamine shock therapy, as we do not believe in the curative value of such dissolutions of consciousness. The Center seeks to have its patients regain self-awareness through verbalization, explanation, and ego reinforcement.

Drama therapy sessions: a story is recounted or a patient speaks of his problems and the rest of the group under observation is invited to comment. Criticism often abounds and sometimes takes the tone of frenzied accusation in the case of mirror identification.

The term sociodrama could be invoked here, with the difference that we try to avoid fictive situations. Priority is given to biographical stories told by the patients themselves. During the course of the narration, patients demonstrate, comment on, and gain awareness of their own responses to conflict, provoking the listeners to take a postion, offer criticism and express reservations. Reciprocally, patients attempt to justify their behavior to others, thereby prioritizing the use of reason over phantasmatic and imaginary attitudes.

We also use psychoanalytic methods at the Center in fairly standard situations: anxiety hysteria, neurotic depression, sexual disorders (impotence, vaginismus, homosexuality), etc.

Since patients do not pay their analyst, transfer neuroses are particularly rare therefore we often intervene to activate counter-transferential dynamics. The rhythm of therapy includes daily 40-minute sessions except on Sundays.

The Tunis Center for Day Neuropsychiatry, created 16 months ago, is the only institution of its kind on the African continent. With a capacity of only 80 beds, it has admitted more than 1,000 patients, less than 1 percent of which had to be

15_Fannon_cha12.indd 134 10/7/2014 5:39:20 PM

referred to La Manouba Psychiatric Hospital. Although a majority of patients were pre-psychotic, we did observe a relatively high number of authentic psychoses. There have been no incidents of medical or medico-legal malpractice.

Part Two: Doctrinal Considerations

The Tunis Center for Day-Neuropsychiatry (CNPJ)

In the course of the history of psychiatry, doctrines governing care for the mentally ill and our understanding of mental illness in both its causality and dynamism evolved as our knowledge became more precise.

Assistance to the mentally ill was first conceived as protection: of society against the sick by way of internment; of the alienated against themselves in asylums that offered soothing, self-contained environments where a life could unfold without drama or crises; an increasingly calm yet decreasingly socialized life.

Subsequently, care for the mentally ill was envisaged as therapeutic and preventative with modernized legislation, the introduction of biologically based methods, the creation of open wards, and the multiplication of dispensaries.

There now exists a mode of care and therapy for the mentally ill, begun just a few years ago, that seemed sufficiently promising to experiment with here in Tunisia: day hospitalization, as inaugurated by the Anglo-Saxon school.

Hence the Tunis Center for Day Neuropsychiatry was created as an outpatient facility of the Charles-Nicolle General Hospital. Patients arrive every morning starting at 7:00 a.m., receive treatment, and return home at 6:00 p.m.

Two features distinguish the Center for Day Neuropsychiatry (CNPJ) from other psychiatric facilities: the fact that it is attached to a general hospital and its daytime practice of hospitalization.

Regarding the first, we think it fundamentally necessary that psychiatric wards be attached to general hospitals, both from our own doctrinal perspective and in recognition of the radically biological and physico-chemical turn in contemporary studies of the nervous system. The psychiatrist is no longer isolated, no longer the relatively alienated alienist doctor of prehistoric times.

Instead, he is able to benefit both from the material infrastructure of the general hospital (radiological units, biochemical, and pathology laboratories) and from access to his colleagues in surgery and internal medicine in the practice of his specialty. Because the psychiatrist is no longer shut up in the asylum with "his madmen," he ceases to bear that phantasmal, mysterious and, on the whole, somewhat disquieting air in the eyes of his colleagues.

In the eyes of his patients too, and we cannot stress this enough, he is just another physician. Hospitalization in the neuropsychiatry ward of a general hospital thus sheds most of its dramatic character. And reintroducing psychiatry as a category of

general medicine effectively corrects well-entrenched prejudices within the general public, transforming the "mad" back into the "ailing."

Nevertheless, the key novelty of day hospitalization is the total freedom it offers patients, definitively breaking with the relative and sometimes absolute coercion that defined internment. Although it is true that the freedom to leave the hospital is also inherent to the open-door approach, it is admittedly mostly a formal one. Every doctor on an open-door ward has been tempted (and often succumbed) to oppose the release of a manifestly ill patient unable to cope with hospitalization and demanding freedom.[6] It seems obvious, and our experience confirms it daily, that day hospitalization, with the possibility of returning to family, friends, and a world of relationality every evening, is easier to accept than complete internment.

All of these methods tend to conceal the crucial question for psychiatry of the patient's consciousness of illness. Internment more or less explicitly signals to patients that they must drop their guard and relinquish themselves to our care, that resistance is futile, that they literally require tutelage and protection. Day hospitalization, on the other hand, offers temporary support and momentary personality reinforcement, akin to a prolonged visit to the therapist.

Patient-therapist relations are thus normalized. The intimidation tactics that medical personnel used on patients, consciously or not, no longer exist nor could they in this context. Patients no longer experience the possibility of release as a product of the doctor's benevolence. The simple dialectic of master and slave, prisoner and jailer, constructed by internment or the threat thereof, is radically severed. Thus the doctor-patient encounter within the context of day hospitalization is always one of two free wills, which is necessary for any form of therapy though even more so for psychiatry.

If we phenomenologically bracket out gross alterations of consciousness, mental illness actually presents itself as a pathology of freedom. Illness situates patients in a world where their freedom, will, and desires are constantly fractured by obsessions, inhibitions, contraindications and anxiety. Classical hospitalization considerably limits what patients can act upon, forbidding any compensation or displacement as they are kept within the bounds of the hospital and condemned to exercise their freedom in the unreal realm of their fantasies. It is not surprising then that patients only feel free in opposition to the physicians restraining them. And as every psychiatrist knows, the hardest patients to treat (i.e., to keep in hospital) are those in the early stages of their illness who believe they can still make it on their own; those who have not yet given up. Objectively, patients who have difficulty accepting hospitalization are the least psychically disorganized: neuroses, minor paranoia, and delusions. Conversely, day hospitalization is often rejected by patients with inactive egos, completely overrun by delusion and who insist upon being fully taken charge of.

Again from the point of view of the patient's lived experience, day hospitalization presents unique characteristics. In a typical psychiatric hospital, therapeutic activities never extend beyond 6:00 p.m. Once medications have been distributed and afternoon group therapy sessions are over, patients are left to themselves. This sense of abandonment is particularly felt in the evening after assistants or interns

15_Fannon_cha12.indd 136 10/7/2014 5:39:21 PM

have done final rounds and when the nurses, already dressed in civilian clothes, quickly pass on their instructions to the night staff. Life from the outside infiltrates the hospital through the plans of the staff: movie nights, evenings with friends, café rendezvous, taking on accrued depth for patients who remain confined to the silence and boredom of the hospital common rooms. This is already distressing for patients immobilized by a fracture, typhoid, or heart failure. For psychiatric patients who literally feel like the coercion of the establishment is the sole reason for their confinement, it occasions contestation and revolt several times a day.

We turned to sociotherapy in order to lessen these kinds of stress factors and to maintain a certain degree of sociability for the patient.

Our understanding of madness took a decisive turn with the creation of a neo-society within the psychiatric hospital, transforming it into a social milieu in its own right by multiplying relations, duties and opportunities for patients to take on various roles and responsibilities. We put this method into effect in Blida with particular zeal.[7] Within this new society, we observed first hand the transformation of the old symptomatology regularly associated with asylums: complete desocialization, gradual decline of the motor sphere in the form of stereotypies, hallucinatory agitation, catatonia, and the likes. Whereas patients require the reverse to heal: they need to be able to verbalize, explain things, explain themselves, and take a stance. Patients continue to invest in an object world that has acquired a new degree of consistency. Sociotherapy thus wrenches them from their fantasies and forces a confrontation with reality on a new register.

Of course, the confrontation remains pathological as it mostly occurs on an imaginary or symbolic plane. But it allows the doctor to study mechanisms of projection and identification, instinctual inhibitions, etc., which then get integrated into the dynamics of treatment. The physician can observe and follow the ego in its efforts to maintain unity and coherence despite a state of serious regression.

However, we must keep in mind that with the institutionalizing of any therapy we create fixed structures with strict, rigid, boundaries, and rapidly stereotyped schemata. There is no space for invention or innovative dynamics; nor any real jolts or crises that take place within this neo-society. The institution remains the "ossifying cement" Mauss spoke of.

Institutional sociotherapy is far from useless however. In large psychiatric facilities such as Blida (with nearly 1,800 patients) or the Razi Hospital in Tunis (with a population of nearly 1,300), sociotherapy effectively helps combat progressive disaggregation of the personality known to take place in such settings. It is especially indispensable in the asylum as it keeps patients socialized, hence actively working against chronic recurrence, leaving patients rotting away within decaying asylum walls, but it rarely cures. Sociotherapy reactivates delusional and hallucinatory processes, provoking new dramatizations so that doctors can better understand "what happened outside." Yet the inert character of this pseudo society, its strict spatial confines, the restricted number of structures available, and, why hide it, the patient's lived experience of internment-imprisonment considerably limit the curative and disalienating value of sociotherapy. Thus, we have come to believe that the only true socio-therapeutic milieu is, and remains, material society itself.

15_Fannon_cha12.indd 137 10/7/2014 5:39:21 PM

Patients and their Pathologies in Day Hospitalization

In relation to professional life, a patient hospitalized at the Center can be regarded as an employee on holiday. In practice, the patient returns home at the same time as factories or workshops close for the day. He might even meet his coworkers on their way home from a construction site on the bus or suburban train. Such encounters are evidently fruitful for the patient since, once treatment is underway, the draw of professional life always appears stronger than the negative valence it carried before hospitalization. The life of the workplace and proximity to coworkers, experienced as a threat before psychiatric intervention, progressively cease to be traumatizing. Instead of being a space where freedom is perpetually scorned, the professional milieu becomes the location of its exercise and reinforcement, hence why the French School, with Ey, defined madness as the pathology of freedom.

Patients regain their old habits at the door when they leave the Center. They continue to be present for rendezvous at the café, evening prayers at the mosque, or participation in a political group. After 6:00 p.m. then, the patient is once again a part of the complex geography of socio-personal coordinates that define his place in the world. He continues to take his place at the table in bi-weekly card games or plays his usual role in the political group he belongs to.

Mothers also remain in constant contact with their spaces of activity. On the way home from treatment, she stops by the grocer's, the butcher's, and the newsstand. She continues to occupy her place in the home, which is temporarily disrupted rather than fundamentally disheveled.

Sunday family gatherings and outings to the countryside to visit grandparents are maintained; cinema, theater, and sporting events continue to inform personal growth by provoking affective reactions, providing choices, and sustaining dynamic relations.

Ties to society are never severed. The therapist is not dealing with an excluded or isolated person but with a personality whose relationship to the world is alive and active. The patient continues to be permeated by society, family, and his professional milieu. Not a single patient has his antennae cut.[8] While in many psychiatric facilities, patients are legally deprived of visits for the first 15 days and confined to a ward where they have nothing but their symptoms to show their psychiatrists.

In a day hospital setting, the psychiatrist has before him an illness experienced by a patient, a personality in crisis within a living environment: the concrete, dynamic study, en vivo, of illness. Therefore a patient's ambivalence is no longer just an affective problem *in abstracto*, isolated as symptom during a delusional crisis or a therapeutic session. It is a manifest, perceptible ambivalence that tears apart the synthetic unity of man and his environment on a daily basis.

Symptomatologies reveal themselves dialectically and it is dialectically that the psychiatrist thinks and acts. The descriptive semiology paramount to the asylum period now takes second place to an existential rather than nosological approach. We see patients living with their illnesses, developing reaction formations, inhibitions, and identifications in their own environments. By observing the behavior of the ego, we are able to understand the dynamics of structures at play, the impoverishment of the ego, and the assaults it faces; in short, we decide on the place and

15_Fannon_cha12.indd 138 10/7/2014 5:39:22 PM

type of intervention required by taking as point of departure a *pathological existence.* Yet our decision dialectically includes all the elements of a situation, contrary to the pointillist approach to various symptoms. Ours is a comprehensive attack on a way of life, a structure, a personality engaged in ever-present conflicts.

In psychiatric hospitals, patients are sometimes allowed to keep personal effects such as clothing, neckties, and belts and in rare cases, electric razors, money, wedding rings... The approach is reversed in day hospitalization. The institution does not have power over the patient's freedom, appearance, or possessions. The initial confrontation with the institution does not bring into question ways of being but rather encourages a progressive questioning of modes of *existence* and existential content. A man hospitalized at the CNPJ can shave everyday in his own kitchen or bathroom with his own razor, choose his own necktie, gaze over a precipice, cross streets, take a walk along the lake, and so on; a woman hospitalized here can bathe, brush her teeth, and put on her makeup in her *gourbi* amongst her own. *Taking care of the self* through one's dress, haircut and, above all, holding on *to the secret of a whole portion of the day spent outside the hospital* maintains, if not reinforces the patient's personality as opposed to the psychical disaggregation brought on by integration into the psychiatric hospital, opening the door to fantasies of corporal fragmentation or the disintegration of the ego.

Both Melanie Klein and Sandor Ferenczi, amongst others, have sufficiently signaled the importance of *cultivating the body* as a means of avoiding anxiety. Internment shatters the patient's narcissism, crucifying his hedonistic attempts, and takes him traumatically down the road of regression and a heightened sense of danger and anxiety.

Day hospitalization also allows us to analyze the particular attitudes of family toward patients and their illnesses from another perspective. In standard psychiatric hospitals, the tendency was for family to disengage[9] and exclude the patient. Although certainly rejection is aimed more at the pathologies than the patients, it is nevertheless experienced as an authentic condemnation of their essence and their truth. By rejecting the pathology and demarcating itself from the patient, the family claims not to recognize the "excrescence." The family chooses to disown one of its members, decides on internment, and thus the family unit is shattered. But isn't the very question mental illness poses that of the foundation of being as subject: "Who am I really?" And isn't this precisely the obsessive interrogation repeated on multiple levels and in different registers by the patient? Therefore, if families signal to patients that they no longer identify with or recognize them, that they are made of fundamentally different essences, how they multiply the possibilities of disintegration, and how innumerable the paths to fantasy and regression!

Day hospitalization allows the family to prolong its battle for unity. It offers them a means of avoiding amputation, allowing patients to keep their place in the family and continue to be bearers of signification, centers of activity, and dynamic elements within it. Day hospitalization allows the therapist to concretely experience the family as *normative value*, intrinsically relying on it as the space of all mediations.

This is how the "vertiginous phenomena of release," spectacular relapses and rehabilitation problems are avoided, patients having maintained ties with their milieu and therapies developed precisely in order to take into account their multirelational realities.

The Presence of Conflict

Day hospitalization both presupposes and articulates a general theory of the dynamics of mental illness. Even though psychiatric symptoms are manifestations of the ego being overrun by abnormally vehement instinctual drives, and of a hopelessly conflictual existence, there is still a strong tendency to remove the patient from the conditions in which conflict emerged and remains active. The pathogenic character of conflict is privileged. During internment, there is *objectification* of conflict, and therefore of the patient. In erecting the wall of the asylum between patient and outside world, we magically negate one of the most essential factors in the genesis of a personality that postulates sameness between conflict and self. One cannot scotomize for long the fact that a conflict situation is the outcome of an uninterrupted dialectic between subject and world. We systematically insist on the event while minimizing the history. This is not merely a matter of biography or anamnesis but of the history of the subject in all that it contains of successive integrations of both conflict and elements key to overcoming it.

A suffering mind cannot heal itself by denying reality. Internment diminishes the violence of conflict and the menace of reality whereas actual healing can only take place at the heart of a syncopated dialog established between the person as a whole and the environment in which fixed pathological structures can be systematically put into question. Action upon the real and upon the patient is an element of the real and therefore unifying. It cannot be developed usefully in a dispersed manner. The patient hospitalized in a psychiatric establishment sees symptoms attenuate if not disappear but they remain foreign, misunderstood, even scandalous. They are not appropriated or thematically organized, and the whole experience therefore takes place solely in the realm of magic.

Some will ask, "Isn't the day hospitalization described here not simply psychiatric therapy in private practice? Isn't it but a form of out-patient therapy?" To this we respond firmly in the negative. The patient in day treatment has limited contact with the conditions of conflict. The therapist controls the effects of conflict on the patient by interposing a daily buffer between him and pathogenic messages from the social sphere or substrates of fantasy. The patient, in effect, spends *less time in conflict situations* giving the ego time to reinforce itself in view of imminent and daily affronts. Hospitalized patients have almost always sought treatment elsewhere beforehand, either in private practices or in various neuropsychiatric dispensaries. With day hospitalization, the neurotic nucleus can be attacked on an existential level while the personality simultaneously effectuates its own restructuring and updating.

The Tunis Center

Our Tunis experience confirmed these theoretical considerations and allowed us to specify the wide range of cases for which day hospitalization can be truly effective.

The Tunis Center for Day Neuropsychiatry was created nearly two years ago. More than 1,200 patients were treated during this period. The Center is divided into two sections (40 places for men, 40 for women) and admits all nosological categories from speech impediments to delusional erotomania, including schizophrenia and attempted suicides.

The absence of a neurological ward at the Charles Nicolle Hospital compelled us to admit neurological cases as well: patients in the early stages of multiple sclerosis, severe and abrupt seizures of undetermined cause, and aggravated or controlled Parkinsonism were all referred to the CNPJ. Whenever the formation of tumors was suspected a pneumoencephalography was performed. Nearly 70 pneumoencephalographies were carried out, either when tumors were suspected or where pneumotherapy seemed necessary: 20 tumors were diagnosed this way and a case of pantophobic anxiety as well as delusions associated with dementia were spectacularly cured. Patients who received 100 to 150ccs of air during these treatments were all easily able to leave the hospital at 5:00 p.m. and not a single complication was reported.

Schizophrenics admitted to the Center, with a majority of the paranoid type, were treated with the classic Sakel cure. Not merely insulin shock, but veritable comas (sometimes up to the fifth degree of the South American scale) were induced. Treatment begins at 7:30 a.m. and the patient is revived at 12:00 noon with the usual techniques. The patient then remains under medical supervision in the afternoon while participating in collective activities and individual psychotherapy sessions. The patient returns home in the evening and the family is given all necessary instructions in case of a relapse into an insulin coma. A telephone number is also given in case of serious complications.[10] Of the more than 100 patients treated by insulin therapy, only one insulin resistant schizophrenic relapsed twice into a nocturnal coma. He was revived without complication.

The various types of usual psychiatric therapies are also used at the CNPJ. We particularly favor individual and group psychotherapy. We form groups of 6 to 8 patients who meet every afternoon. Each patient is asked to speak about his problems while the others, in turn, are asked to comment on the strategies adopted by the patient. Thus various mechanisms of projection, identification, etc. are exposed and explained for each patient, always within concrete lived situations. Individual psychotherapy is practiced daily in conjunction with group therapy, ranging from basic support psychotherapy to the psychoanalytic cure, including psychotherapies that utilize psychoanalytically inspired techniques. Our psychoanalytic practice is one of appeasement in which we encourage the reconstruction of fantasies and generally adopt an active approach in the Ferenczian sense.

Although day hospitalization is a remarkably effective therapeutic tool, there are cases where it proves insufficient or inapplicable. For instance, in cases where the organic component of the mental illness is massive or dominant and poses serious therapeutic problems: mainly acute psychoses—manic or confusion—that require urgent therapeutic intervention and constant medical supervision.[11] In fact, thanks to advances in chemotherapy, total hospitalization time can be considerably reduced and patients transferred to day hospitalization early on. This holds true for the acute outbursts that mark the onset of grave psychoses like schizophrenia,

15_Fannon_cha12.indd 141 10/7/2014 5:39:23 PM

delirium tremens, with its biological component that escapes the capacities of day hospitalization and organic dementias. Finally, patients with active delusions causing dangerously aggressive behavior and, of course, medicolegal cases that are under investigation by the police also fall outside the jurisdiction of day hospitalization.

A whole category of illnesses thus escapes the purview of day hospitalization; a non-negligible one that constitutes much of the clientele for traditional psychiatric hospitals. Aside from the problem of dementia, however, which still responds solely to asylum care, all the other cases can conceivably be treated by day hospitalization once acute symptoms have subsided. Another problem that arises with day hospitalization is patients who live too far from the hospital to make the journey back and forth daily. Alongside distance are the cases of economic and physiological impediments to travel that prevent this kind of hospitalization.

If we wish to multiply the number of psychiatric or neuropsychiatric wards in general hospitals then—and this should be the objective of any plan to address the question of mental illness—we must find a solution that alleviates the inconveniences of day hospitalization while conserving the method itself which we find ideal. Much of the existing infrastructure can easily be made to accommodate day hospitalization. For example, departmental psychiatric hospitals might be transformed into psychiatric wards that would treat acute cases for limited stays. One might also imagine a mixed formula whereby a number of beds are reserved for day hospitalization while the rest are kept for fulltime care. In this case, the provision of strict legislation is advised in order to prevent day hospitalization from becoming a classic open ward: for instance, reserving full hospitalization for patients residing far away from the hospital and restricting the duration of hospitalization for acute cases. These are only a few examples but we might easily imagine more. One thing is certain: we must avoid the creation of monstrosities the likes of classic psychiatric hospitals at all costs.

Conclusion

Our experience in Tunisia, after more than 20 months, has allowed us to verify the soundness of the theoretical foundations of day hospitalization in psychiatry. On both therapeutic and preventative levels, the CNPJ at the Charles Nicolle Hospital has proven its efficacy. The large number of patients treated (more than 1,200) and the reduction of average stay to 25 days are eloquent enough and speak for themselves.

Furthermore, our experience shows that this technique, originating in countries with high economic development, can be transplanted to a so-called underdeveloped country without losing any of its value. Day hospitalization is, by far, the type of psychiatric care most suited to the treatment of mental illness and best able to integrate recent findings on the etiology of mental disorders. Any nation's plan to endow itself with adequate psychiatric infrastructure should start by multiplying small psychiatric wards within general hospitals, mainly dedicated to day hospitalization. A few autonomous psychiatric hospitals might be built on the condition

15_Fannon_cha12.indd 142 10/7/2014 5:39:24 PM

15_Fannon_cha12.indd 144 10/7/2014 5:39:24 PM

they be reserved for those categories of patients who absolutely cannot be treated in hospital psychiatric wards, whether open-door or day hospital. In any case, they should be of limited number and reduced capacity. It seems absurd to build psychiatric facilities with more than a 200-bed capacity today. Finally, very strict legislation should be passed guaranteeing the patient's freedom to the maximum and discarding all carceral and coercive aspects of internment

Notes

* In collaboration with C. Geronomi. First published in *La Tunisie Médicale* 38.10 (1959).

1. TR: Known as the "*loi des aliénés*." Most well known for attempting to regulate internment by distinguishing between voluntary and involuntary placements on doctor's orders only, multiplying the number of psychiatric hospitals, creating opportunities for work within the asylum and defining the legal status of patients. Despite severe criticism, it remained in effect until 1990.
2. The paucity of medical personnel considerably restricts the ward's therapeutic capacity. For over a year, neither interns nor assistants have been made available despite an 80-patient capacity. The head physician must therefore take on all therapeutic decision making.
3. Patients are admitted after an external consultation in Charles Nicolle Hospital's neuropsychiatric ward. Every day, a neuropsychiatrist is present to take these consultations.
4. TR: Literally, the older you get, the better you feel/the older you get, the better you put up with yourself.
5. These are authentic Sakel cures. As a point of reference, we push to the fifth degree of the South American nomenclature. It often happens that old insulin-resistant schizophrenias receive doses up to 400 or 500 units of insulin.
6. One of the authors opened and spent two years directing the only open-door center in Algeria. French legislation applied in Algeria allows an open hospitalization to be converted into a forced one on medical grounds.
7. See Azoulay's thesis: *La Socialtherapie en milieu nord-africain* [Sociotherapy in a North-African context], Algiers 1956.
8. TR: French expression meaning losing touch with the world. Because both translations of BSWM use the term antenna, we chose to keep it for the sake of lexical continuity.
9. Which proves, on a phenomenological level, that if the mentally ill shuns society, society will stop trying to reach out after a certain point in the evolution of the illness.
10. We explain the reasoning behind the choice of therapy, how the treatment works and the role the family is to play. We think this explanation plays an important role as it inserts the family constellation into the healing process.
11. Several cases of colibacillary or postpartum confusion psychosis were successfully treated at the CNPJ however.

Chapter 13

The Encounter of Society and Psychiatry*

The "mad" are "strangers" to society and society thus seeks to rid itself of these anarchic elements. Internment means rejection, pushing aside the ill, and society asks psychiatrists to render them once again fit to reintegrate its ranks. The psychiatrist is the auxiliary of the police, the protector of society.[1] Social groups seek to protect themselves by locking up the ill. When a patient leaves the institution without a physician's approval, there are immediate consequences. Psychiatrists have reacted violently against this role, insisting that authorities grant a certain measure of spontaneity to both patient and family. This new approach has borne fruit. We shall see further on how the mentally ill are able to gain consciousness of their illness by practicing self-placement.

The issue of a patient's consciousness of his illness poses problems. There is no means of certifying if a mental illness has disappeared; at what point can we say that the sick are cured?

Since 1930, sociologists have provided psychiatrists with interesting data. Because the ill have effectively lost a sense of the social, they must be resocialized. For some, a socialized being is one who is able to carry on living without being unduly noticed. Only, to which group should they adapt? We realized that some patients were easily admitted back into the family group while the work environment proved more difficult and vice versa. There are sexual perverts who are successful according to societal standards. Schizophrenics of the catatonic type tend to withdraw from society; there are moral masochists out there: are they abnormal? Is the purpose of man never to pose problems for the group?

It is also said that a normal man is one who does not make trouble. But then, are trade unionists who make demands and protest against government decisions normal?

What is the criterion of normality? For some, the criterion is work—but a prostitute works! Though she might also be neurotic. Likewise, is an unemployed worker ill? Many of the unemployed fall ill, but is it because they are unemployed?

16_Fanon_cha13.indd 145 10/7/2014 5:37:06 PM

Physicians are situated somewhere between society and the ill. For example, when it comes to correspondence, the physician reads all letters from society to the patient. And society strives to control the psychiatrist's work. The patient often seems cured yet relapses when released, sometimes gravely (suicide attempts for example); hence the effort to create a society within hospital walls, which is *sociotherapy*.

Before, life in the hospital was organized and divided into quarters, rooms, and cells. The essential tool was the *key*. Sociotherapy is based on a few main principles:

a) *Madness is forbidden in the hospital*: Before, screaming patients were said to be merely fulfilling their function as mad. All pathological manifestations must be linked to something; reason must oppose the patient's unreason. This is an extremely rich experience for those who practice it. A sane brain, with unobstructed neuronal connections, cannot be sick. Through these connections, a kind of doorway is opened that the physician must find his way into *with innovative principles*, therefore *madness is permitted*.
b) *Modifying the daily rhythm*: Daily routines were formerly arranged by category. A rhythm was imposed. We created dining rooms, distributed forks and napkins and asked that patients exhibit normal behavior. A patient must work and be compensated. Contests are organized, and meetings that patients must attend in the doctor's presence. The issue of group tolerance toward patients is of utmost importance.
c) *Problems with sociotherapy*: tolerance of patients can lead to extensive material damage; Anglo-Saxon doctors created quasi-police quarters staffed by village constabularies.

Some have remarked that sociotherapy creates a false society, but can we really domesticate the social environment the way we have the natural?

Socialization in terms of brain matter

We will now leave behind the classical sociological perspective and look at neurophysiology.

The bipedal position stood the body upright, tilted the head, remodeled the face, and increased cranial capacity: this process of hominization deserves further examination:

- Increasing complexity of the nervous system and the brain, reaching its final stage in the human brain with the exaggerated development of its hemispheres.
- Two types of integration: subcortical integration (the cerebral cortex is not very developed in many animals); in humans, development of the cerebral cortex. Subcortical integration gave way to the cortical. The human brain is not

16_Fannon_cha13.indd 146 10/7/2014 5:37:06 PM

only larger but also more complex. A maximum of neurons means a maximum of faculties. There are association fibers in abundance; all points of the brain are linked to all others.

How does the brain function? It works like any ordinary animal protoplasm (phenomena of polarization and depolarization.)

Is the human brain a given? a finished product? Are children born with brains that develop as a function of endogenous phenomena (Cuvier's thesis); or is the brain a social product (in the beginning there is nothing), as suggested by Lamark?

There is hemispheric dominance: the center of language is found in the left hemisphere therefore children with right-sided hemiplegia can speak. When the left hemisphere is affected, an inversion takes place and the right side of the brain takes the place of the left. The deaf are not born mute: since they cannot hear themselves, the first motions of speech are progressively abandoned. Hence, a child becomes mute because he is deaf.

The human brain is endowed with enormous potentialities, but these potentialities must be allowed to develop within a coherent environment. Messages delivered to the brain must be able to be received.

Being socializable means first, having a normally constituted brain. Although this is a necessary condition, other factors intervene. Piaget accords great importance to language, yet there is a preliminary stage before language.

For the brain, there is consubstantiality between "me" and "us." We cannot say that a child is egocentric and does not see the outside world. Otto Rank described his "famous" trauma of birth. But in the practice of painless childbirth, one realizes that giving birth is a physiological not a pathological act.

Let us base ourselves on a few facts:

a) A baby of six months is unable to sleep without a light on: it has always slept with the lights on; a sort of intoxicating effect on brain cells has taken place.
b) A baby of three months develops dermatitis resistant to any treatment: its mother nursed it as if it were a repulsive object.
c) A baby two-and-a-half months old does not sleep or eat, and even when it does start eating again, it continues to lose weight: the parents don't sleep either. Entrusted to its grandmother, the baby gains weight and begins sleeping again.
d) A baby of 14 months does not sleep and is aggressive: the father was unemployed and beat his wife.
e) A baby of 14 months vomits uncontrollably: this appears to be due to the parents' attitude toward the child; the father doubts his paternity.
f) A child doesn't smile: the mother has dual facial paralysis.

From the very first weeks stereotypes appear. The social environment is a constant presence; from the first minutes of life, a child is in the care of the social milieu.

If some children speak late, it is generally because inhibitions installed in early childhood must first be lifted. Cases of dyslexia can be treated.

The Formation of the Ego

The neurological view agrees with the psychoanalytic view that everything is put into place during the latency phase. According to Lacan, the newborn is "fragmented" (i.e., associations have not been established.) At six months, a transformation takes place: the child recognizes its mother's image and acquires the certainty that the other is equal to "me." Lacan calls this the mirror stage: if a child is placed before a mirror at four months, nothing happens; but at seven months there is extraordinary jubilation—a recognition that it links to the maternal image. The fact that I am myself is haunted by the existence of the other. For man, the mirror stage is a standard stage; a child reacts to human faces very early; it is a conditioned reflex.

Children are quite sensitive to changes in atmosphere. The brain is not constitutionally weak. Being socializable is being able to maintain a constant tension between self and society. With language things get complicated: the word becomes the sign of a sign. If the milieu does not allow me to respond, it is clear that I will atrophy, that I will be stopped, arrested; that I cannot acquire a normal rhythm; if the milieu imprisons me, conflict ensues. There is absence of a perspective open to the fractional complexity of the brain.

To be socialized is to respond to the social milieu, to accept that the social milieu influences me.

Control and Surveillance

It is said that modern times are characterized by man being put on file. Psychiatrists intervene when man is made part of a schema of labor or technique. A man working in a team, on an assembly line, requires control.

Before, the object was controlled, the work put into a material object was controlled: this was qualitative control. With the development of the market, a kind of quantification was introduced. It became a question of work hours, of the number of hours of presence within a chain of production. This was the origin of punch card attendance machines.

The punch card machine has nicknames: the "haggler," the "grandfather"; the boss calls it the "antitheft" machine. To be a good worker is to have no history with the punch card machine. Relations between worker and machine are strict, timed to the second. Man feels the presence of the punch card machine as a weight. To be on time for the worker is to be at peace with the machine. A moral notion of guilt is introduced here. The machine prevents and limits the endemic guilt of the worker. The machine is indispensable to the boss. Because of its constant presence, the machine introduces a variety of new behavior amongst workers. It represents the entire apparatus that employs the worker. Before the machine, the worker could excuse himself; from then on, the worker is constantly thrown back to his solitude by the impossibility of persuading the employer of his good will.

16_Fannon_cha13.indd 148 10/7/2014 5:37:07 PM

Hence, the pathological behaviors observed:

- Nervous tension; explosive tempers
- The dreams of these workers are in fact nightmares:
  - A train that leaves without me
  - A closing gate
  - A door that does not open
  - A game I'm not allowed to play
  - The boss has disappeared and left in his place the machine.

But it is not just the relation that is reified; the employee is too. Hence:

- absenteeism: The worker arrives late but does not go inside for fear of receiving a warning. Instead, he goes to the doctor to obtain sick leave. Yet the control factor is still present. However, the factory worker is no good at lazing around. He feels boredom; he feels excluded from the group, displaced.
- Reinforcement of obsessive attitudes: time is no longer something within which I move in an orderly fashion, it is something I must constantly keep track of.
- Accidents: there are 50 percent more accidents before work than after, even though the worker is more tired after work.
- Loss of reflex control.

Are there ways to prevent these disorders? Bosses and the collectivity would first have to take notice of them.

The Neuroses of Telephone Operators

The context studied was central Paris. Louis Le Guillant studied a number of cases and noticed the following phenomena:

- The sensation of being brain dead. Intellectual work impossible
- Impossibility of giving birth without pain: loss of reflex control
- Obsessive phenomena
- Mood swings endured by spouse and family. Employees can't stand noise
- Insomnia
- Somatic disorders: not eating; constant illness; all of which effect marital life.

Where do these disorders come from? Too many phone calls; headphones have to be kept on. Le Guillant also discusses the switchboards controlled by the supervisor: employees feel constantly spied on; they must constantly control themselves. In its manifestations, the body is plagued by the hallucinatory perception of ears. The role of an employee is to establish communication, plug in files, abstract herself from the situation.

16_Fannon_cha13.indd 149 10/7/2014 5:37:07 PM

In public services, telephone operators are not under surveillance and so their disorders are solely due to the mechanized nature of the profession and not to the switchboard or headphones. We have here an example of what we call in psychiatric terms the "exterior action syndrome" [Claude's syndrome] which causes deformation and often leads to suicide.

Employees of Department Stores

In the United States in particular, cameras are set up in department stores without informing the employees; there is constant surveillance. Ostensibly, this is not only to watch employees but especially to watch out for thieves. Regardless, employees know they are constantly spied on. Hence syndromes of the same type as the telephone operators spied on through the switchboard .

Within the technological environment then, the trend is to reduce communication and transform man into an automaton.

The Problem of Racism (United States)

In compartmentalized societies, one observes behavior characterized by the predominance of nervous tension that quickly leads to exhaustion. Among Black Americans, a permanent control of the self is required at all levels: emotional, affective...

This partition called the "color bar" is unyielding, and haunting in its ever presence. When reading the detective novels of Chester Himes (A *Rage in Harlem, The Crazy Kill*, etc.), you get the sense that aggressiveness is everywhere in Harlem. By a kind of introjection, Black aggression is turned against Blacks; the condemnation is turned against the self; Blacks "take on" their own condemnation.

Note the widespread feelings of guilt amongst Blacks and Jews.

It is understandable that the "Negro" wants to leave Harlem; but it also implies wanting to be white. Religion is often conceived as a process of "self-whitening." Sometimes there are other kinds of attempts at escape (e.g., *Green Pastures* by Marc Connelly) like those claims that Paradise is Black, that Jesus Christ is Black.

- The theme of escape in Negro spirituals, of departure and flight.
- The desire for greatness, to be champion of something. Hence the historic revenge of the Black American during sporting events like the Olympics.
- Obsessive fear of suicide: for example, the Blues and other Black American music. In certain Blues songs, the aggression is very clear: "I pray to God that this train going East crashes, that the engineer is killed." Often, the Black man's only recourse is to kill.

When one Black kills another, nothing happens; when a Black kills a White, the whole police force is mobilized.

The Problem of Encountering the Other

In a society as compartmentalized as American society, to what extent is it even possible for a Black to meet a White? When a Black American meets a white man, stereotypes immediately intervene; he cannot be "truly" himself with the white man because their systems of value are not the same; at base there is a lie which is the lie of the situation itself. To confess is to confess belonging to one's own social group. If Blacks are dominated, one cannot demand that they behave humanly. When a Black man addresses a White man, he takes on a particular voice, with a particular turn of phrase and style.

When Whites intervene in Harlem, racial solidarity manifests itself immediately.

Psychopathologies

Society intervenes in personality development from infancy. The theme of negritude already appears in nursery rhymes: "*Dors, dors mon négro, prends ton bon temps, parce qu'après ce n'est pas drôle.*"[2] It is a kind of conditioning by the absurd. A space is cordoned off with all that doing so entails of prohibition. There are intense psychological and muscular tensions that produce cephalgias, ulcers, and severe anxiety. Rejection produces inferiority complexes. The difficulty of defending one's self-esteem devalorizes self-esteem. At the same time, susceptibility and hypersensitivity run high.

"Colonized" Society

The same kinds of responses are found in territories under foreign domination. Some Algerians enlisted in the German army hoping the Germans would liberate their country. The Manifesto of May 31, 1943 demanded the right of self-determination for all Algerians.

Algerians were tremendously reticent to fight in the War. It is said that "the enemies of our enemies are our friends." In 1939, the Algerian people were convinced that the Germans would triumph. Hitler was referred to as "Hadj Belgacem." In 1942, territorial militias were formed. But politicians, who understood full well what Nazi ideology was about, explained that there was no use harboring vain hopes. Even in Iran and Iraq, pro-Nazi movements were above all anti-English or anti-French.

Values shift with independence. When independence is gained, there is no more glory for the veteran. Aimé Césaire said that if Europeans were against Hitler it was only because Hitler tried to apply to them what they had applied to the people they colonized.

16_Fannon_cha13.indd 151 10/7/2014 5:37:08 PM

Ethnopsychiatric Considerations

The Malagasy have been described as dependent, the Hindu as indolent.

In 1918, a professor of Neuropsychiatry, Professor Porot of the Faculty of Algiers, published a treatise on "Muslim Psychiatry" where he characterized the Muslim by his:

- Absence or near absence of emotion
- Credulity
- Tenacious stubbornness
- A propensity for accidents and hysteria.

In 1932 (*Annales medico-psychologiques*), however, he stated that the Kabyle was intelligent—an exception to the mental retardation obvious in other Algerians. In 1935, during the presentation of a report, Baruk stated that Algerians were severely retarded; primitive beings whose lives were essentially vegetative and instinctual; their reactions to the slightest psychical shock were diencephalic rather than psychomotor.

Professor Sutter returned to the question: "Primitivism is not a lack of maturity, it is a social condition at the term of its evolution." Thus primitivism cannot be explained by domination. Primitivism is applied with the use of logic to ways of life different from ours; hence Sutter's argument goes much deeper.

The work of the Algiers School is not unique. Similar remarks were made by Dr. Paul Gallais in Marseille regarding the *Tirailleurs sénégalais*. Dr. J. C. Carothers did a study on the Mau-Mau revolt in Kenya and sought to bring the notion of jealousy into play (the British favoring certain tribes over others): a frustrated love for the father symbolized by the British colonizer. Carothers maintains that Africans, with their total lack of aptitude for synthesis, resemble lobotomized Europeans. The African is constitutively lobotomized: see *The African Mind in Health and Illness* (1954.) He was invited to present his findings at the World Health Organization.

The Relation of the Colonized to Work in a Colonized Society

To study collaborative relations between the colonizer, the native-born settler and the colonized is to reveal what is actually no relation at all.

The Colonized Worker and the State: The state presents itself as a foreigner. The agricultural worker in the rubber plantations of Indochina or the miner in Southwest Africa has nothing in common with the Metropolitan (French) peasant. The settler, the boss, has imposed his presence by force. The Metropolitan flag hoisted on colonized land is a violation. There is a certain homogeneity amongst the miners of Northern France: even if demands differ, they are made within the national context, within the same world. The only modality of struggle conceivable to the colonized is the radical contestation of domination by another country.

16_Fannon_cha13.indd 152 10/7/2014 5:37:09 PM

Before the foreigners arrived, the colonized state did not exist, or it existed as such in its natural state. The Metropole exerts its presence over nature itself and over human beings insofar as they are still in the state of nature. Labor, insofar as it enriches man, is the privilege of the settler—only the settler works to cultivate both nature and beings. Natives and the bush, Mitidja[3] and stubborn idleness, are considered one and the same. Just as roads must be opened, leprosy and malaria must be eradicated *against* the indigenous population. Nature must be transformed in spite of itself. It must be violated. The natives must be brutalized in order to do them good, in spite of themselves. When the gold of the Transvaal is mentioned, we think of the settler's stubborn persistence. But are the natives really hostile? It is more like inertia, abulia, stagnation, a desire to perpetuate the present state of things, hence the difficulty in getting anything done: the natives are idle. The study of labor in the colonies is, to a certain extent, the study of idleness—see Terre's article on this subject in *Présence africaine* (1952.)[4]

This notion of lack of effort and uncooperativeness amongst the colonized is a constant in Metropole/colony relations. In order to create great works and humanize nature, force must be exerted: this is the definition of forced labor. Forced labor is the settler's response to the native's idleness. Natives are forced to work; they will be "cured" at home. Forced labor is a logical consequence of colonial society. Since natives can be forced, it is understood that they can also be beaten.

Their idleness defies the rapacity of settlers, their eagerness to make money. Laziness in the colonial context is lived as the will to render profit-making difficult. It is the behavior of a pilferer. The settler does not work with a notion of eternity in mind; he works for gain in his own lifetime. That is why investment makes no sense from the point of view of the colonial state, for to invest is to have both feet solidly in the future of the region. Private industry cannot invest in the colonies. The settler does not come to the colonies with a plan for economic development but only to amass maximum profit in a minimum amount of time.

If we consider the *union question*, we see that it is posed in very specific terms. First of all, the unionism of the Metropole was implanted with the same directives used in the Metropole itself. The same goes for political parties. The problem is not posed in a heterogeneous fashion but in a homogeneous one. Union directives were the same in the colonies as they were in the Metropole. Thus unionized colonial workers were already specialized workers or functionaries; there was no question of unionizing agricultural workers. Unionized workers were already "*assimilés*" on an economic level and could not be called upon to participate in any kind of national consciousness; and the 87 percent of nonunionized labor was not able to address the question in similar terms. But national consciousness will spread amongst workers and employees eventually.

The Notion of the Unemployed

There are no workers without work in the colonies, only natives whose energy has not yet been claimed by colonial society. These constitute a reserve in case of defection

by other workers. According to Prof. Porot, the North African grows senile quite quickly (around 35 or 40.) Unemployment is not a human problem, but one of constituting an unlimited reserve of labor; firstly to replace the prematurely senile, or in case native workers make demands, a reserve to blackmail them into accepting prohibitively low salaries. Massive unemployment does not bother the colonizer.

If there is no unemployment, if all children go to school and universities are open to all, it is not a colony. Unemployment must be endemic, like yellow fever or malaria; but statistics show that the presence of tropical diseases is considerably diminishing in many regions. It is a question of introducing new types of relations into a society, but introducing new relations is negating the colonial system.

Is the colonized lazy? The idleness of the colonized is a means of protection, a measure of self-defense above all physiological. Work was conceived as forced labor in the colonies and, even when there is no whip, the colonial situation itself is a whip. It is normal that the colonized refuses to do anything since work leads nowhere for them.

Labor must be reclaimed as a mode of humanizing mankind. When man throws himself into work, he not only fructifies nature but also himself. Relations should be fructifying with generosity. Thus nature would be reformed, modified, but only because man would be forging himself.

Resistance is the right course of action for the colonized.

Notes

* First published by CRIDSSH, University of Oran, from notes taken by Lelia Bensalem of Fanon's lectures in Tunis, 1959–1960.

1. TR: This sentence continues, "the protector of society against . . . ," and stops there.
2. TR: "Sleep, sleep, my Negro, take your sweet time, for when you wake, it won't be fun." I was unable to figure out what line from what spiritual he was translating or more likely paraphrasing here.
3. TR: The name of a plain in Algeria.
4. TR: Possibly a reference to the 1952 issue of *Présence Africaine*, "Le Travail en Afrique Noire." There is no author by the name Terre referenced in the table of contents, but a number of articles touch upon the question of labor and idleness in the colonies.

16_Fannon_cha13.indd 154 10/7/2014 5:37:09 PM